Description of document:	Each outgoing letter from the Department of Veterans Affairs (VA) Inspector General (OIG) signed by the Inspector General, resulting from a search of the Executive Correspondence files dated between September 1, 2016 - December 31, 2016
Requested date:	03-January-2017
Released date:	31-January-2017
Posted date:	13-March-2017
Source of document:	FOIA Request Department of Veterans Affairs Office of Inspector General Release of Information Office (50CI) 810 Vermont Avenue, NW Washington, DC 20420 Email: vaoigfoia-pa@va.gov Fax: (202) 495-5859

Department of Veterans Affairs
Office of Inspector General
Washington, DC 20420

January 31, 2017

This is in response to your Freedom of Information Act (FOIA) request dated January 3, 2017 in which you asked for a copy of each outgoing letter from the VA OIG signed by the Inspector General, resulting from a search of the Executive Correspondence files dating between September 1, 2016 through December 31, 2016. Your request was received in this office on January 3, 2017.

We have assigned FOIA Tracking Number 17-00105-FOIA to your request. Please refer to it whenever communicating with VA about your request.

We have enclosed a copy of the requested records. However, we are withholding certain information under FOIA Exemption 3, which permits Federal agencies to withhold information which is exempt from disclosure by another confidentiality statute. The confidentiality statute applicable to your request, 38 U.S.C. § 5701, generally provides for the protection of VA patient information. The statutory protection for this information continues beyond the death of the subjects of the records. Please be advised you may be entitled to more information if you provide us with documentation stating you are legally entitled to receive the information.

We are also withholding all information which, if disclosed, would constitute a clearly unwarranted invasion of an individual's personal privacy under FOIA Exemption 6, 5 U.S.C. § 552 (b)(6). Specifically, names, job titles and other information which could reveal the identity of individuals mentioned in the records have been withheld. We do not find any public interest that outweighs the privacy interests of the individuals.

You may appeal this decision within 60 calendar days of the date of this determination by submitting a signed, written statement by mail, fax, or email. You may submit your appeal by using either of the following addresses or fax number:

U.S. Department of Veterans Affairs
Office of Inspector General

Office of the Counselor (50C)
810 Vermont Avenue, N.W.
Washington, DC 20420

VAOIGFOIA-Appeals@va.gov

(Fax) 202.495.5859

The appeal should include:

1. The name of the FOIA Officer
2. The date of the determination, if any
3. The precise subject matter of the appeal

If you choose to appeal only a portion of the determination, you must specify which part of the determination you are appealing.

The appeal should include a copy of the request and VA's response, if any. The appeal should be marked "Freedom of Information Act Appeal".

Sincerely,

MICHAEL SOYBEL
Acting Chief, Release of Information Office

Enclosures

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP -1 2016

The Honorable Thad Cochran
United States Senator
190 East Capitol Street
Jackson, Mississippi 39201

Dear Senator Cochran:

This is in response to your June 10, 2016 letter on behalf of (b)(6) (b)(6) regarding their protest of a Notice of Reclamation for funds deposited in the bank to the benefit of [redacted] after she was deceased. (b)(3):38 U.S.C. 5701

On March 27, 2014, staff of the Office of Inspector General's (OIG) Office of Investigations had a discussion with (b)(6) regarding VA benefits that had been paid into the Bank on behalf of the then-deceased [redacted] The Bank received a Notice of Reclamation from the Department of Treasury on October 16, 2015 for the benefits paid after [redacted] death. Subsequently, the Bank filed a Protest of the Reclamation, stating the Reclamation was not initiated within 120 days of VA's learning of [redacted]'s death, which (b)(6) believes was as late as March 2014, when she spoke with OIG staff about the funds. (b)(3):38 U.S.C. 5701 (b)(3):38 U.S.C. 5701 (b)(3):38 U.S.C. 5701

The OIG notes that financial institutions have an obligation to return Federal funds if they have knowledge of the death of a recipient, per 31 CFR 210.10. In the protest, (b)(6) certified the Bank learned of [redacted]'s death on January 15, 2010, thus confirming the Bank had notice in 2010 that it was receiving funds for a deceased individual. As the so-called "Green Book", *A Guide to Federal Government ACH Payments* notes, financial institutions need not wait for a Notice of Reclamation to return payments to the Federal Government. The Bank's certification is attached for your review. (b)(3):38 U.S.C. 5701

The above notwithstanding, the OIG also notes that it has no part to play in the reclamation process, once it completed its investigation. Accordingly, concerns with the reclamation process should be addressed to the Disbursing Office, as referenced in the Green Book excerpt (b)(6) provided that was attached to your June 10, 2016 letter.

Thank you for your interest the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP - 1 2016

The Honorable Patrick McHenry
Member, United States House
of Representatives
128 West Main Avenue, Suite 115
Gastonia, North Carolina 28052

Dear Congressman McHenry:

This is in response to a series of emails between our staff regarding a complaint filed on behalf of (b)(6) The Office of Inspector General (OIG) Hotline did receive an inquiry on his behalf from a third party through the OIG's website.

When the OIG receives a complaint through the website, an automatic response is generated to the complainant. In this case, since (b)(6) was not the complainant, the response would have been sent to the person who made the complaint on his behalf. Attached is the current version of automatic response. The original submission was in December 2015, so the version that went out may have been somewhat different as we do update and clarify language in the response from time to time.

As our staff discussed in emails, the underlying issue in the complaint is related to (b)(6)'s compensation rating. The OIG does not intervene in the determination of veterans' benefits rating decisions. Decisions on individual benefits claims are the responsibility of the Veterans Benefits Administration. (b)(6) or his representative should have been provided information on how to appeal the decision if they disagree with it. If not, they should contact the VA Regional Office in Winston-Salem for that information.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 12 2016

The Honorable Ralph Abraham, M.D.
Member, United States House of
of Representatives
2003 MacArthur Dr., Bldg. 5
Alexandria, Louisiana 71301

Dear Congressman Abraham:

This is in response to your August 19, 2016 letter on behalf of (b)(6) regarding a Hotline complaint he filed with the Office of Inspector General (OIG). The VA Congressional Liaison Service referred your letter to the OIG on August 22, 2016.

Mr. (b)(6) submitted a Hotline complaint on April 6, 2016 alleging favoritism for a fellow employee by lab management. Since (b)(6) submitted his complaint through the internet, he would have received an automatic response as to what to expect next from the OIG. Enclosed is the current version of an automatic response. The original submission was in April 2016, so the version that went out may have been somewhat different as we occasionally update and clarify the language in the response.

The OIG does not accept complaints on personnel matters, such as work environment, that can be addressed in other legal or administrative forums. For further assistance, (b)(6) may wish to contact the VA Office of Resolution Management (ORM), the organization within the Department of Veterans Affairs with responsibility for providing a variety of services and programs to prevent, resolve, and process workplace disputes. He may also contact the U.S. Office of Special Counsel (OSC), a separate Federal agency with authority to review allegations of prohibited personnel practices, including reprisal for whistleblowing. ORM and OSC can be reached at:

VA Office of Resolution Management
810 Vermont Avenue, NW
Washington, DC 20420
1-888-737-3361

U.S. Office of Special Counsel
1730 M. Street, NW, Suite 218
Washington, DC 20036
1-800-872-9855

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 12 2016

The Honorable Steny Hoyer
Member, United States House
of Representatives
US District Courthouse
6500 Cherrywood Lane, Suite 310
Greenbelt, Maryland 20770

Dear Congressman Hoyer:

This is in response to an email from your staff dated December 15, 2015, on behalf of (b)(6) relating to allegations about misuse of funds by the fiduciary of her late father, (b)(3):38 U.S.C. 5701 We previously advised you on January 11, 2016 that the appropriate office within the Office of Inspector (OIG) would be reviewing this matter.

The OIG's Office of Investigations conducted an investigation of the allegations that the former fiduciary of (b)(6) 's father misused his funds. We presented the case to both the Criminal and the Civil Divisions of the U.S. Attorney's Office for the Eastern District of North Carolina. Both Divisions declined prosecutorial action. We also discussed the case with the Onslow County (North Carolina) Sheriff's Department and they declined any involvement in this case. The matter has been referred back to VA's Fiduciary Hub in Columbia, South Carolina for whatever administrative action they deem appropriate.

We received your additional inquiries on (b)(6) 's behalf including her allegations that the investigation by the OIG was not conducted thoroughly or with due diligence. We take these allegations seriously. We have conducted an internal review of this matter and determined that matter was sufficiently investigated and presented for prosecution. With declinations from the various prosecutorial entities, further work by the OIG is not warranted.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 12 2016

The Honorable Emmanuel Cleaver, II
Member, United States House
of Representatives
211 Maple Avenue
Independence, Missouri 64050

Dear Congressman Cleaver:

This is in final response to a request from your staff, which we received on March 28, 2016 on behalf of (b)(6) alleged she did not receive appropriate care from the Kansas City VA Medical Center (VAMC) in Kansas City, Missouri. We informed you in a previous letter dated May 27, 2016 that the Office of Inspector General referred the allegations pertaining to her wound care to the Director of the VA Heartland Network (VISN 15), who has managerial oversight of the Kansas City VAMC, for review and response.

We have received and reviewed the VISN 15 Director's response, and we have closed our inquiry. Enclosed is a redacted copy of the VISN 15 Director's response. We made minimal redactions in accordance with exemption (b)(6) of the Freedom of Information Act, which authorizes the withholding of information that, if disclosed, would invade another individual's personal privacy.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General

Administrative Investigations Division
801 I (Eye) Street, NW, Suite 1056
Washington, DC 20001

September 12, 2016

Refer To: 2014-01540-IQ-0089

Ms. Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 218
Washington, DC 20036-4505

Dear Ms. Lerner,

The VA Office of Inspector General received the following allegations of improper hiring actions within VA's Human Resources and Administration (HRA):

1. (b)(6) (b)(6) (b)(6) and HRA staff provided (b)(6) with preference and an advantage to improve her prospects for VA employment.
2. (b)(6) while (b)(6) afforded (b)(6) (b)(6) preference and advantage to improve her prospects of VA employment.

Our investigation developed evidence suggesting that prohibited personnel practices may have been committed in the above appointments. Attached is a summary of our investigative results, together with one compact disk comprising the associated evidence package, for your consideration and action as you deem appropriate.

If you have any questions, please contact me at (202) 461-4720.

Respectfully,

Michael J. Missal
Inspector General

Enclosures: As stated.

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 14 2016

The Honorable Patty Murray
U.S. Senate
Washington, DC 20510

Dear Senator Murray:

This is in response to your April 30, 2015, letter requesting the Office of Inspector General (OIG) review the current status of the Emergency Department at the Mann-Grandstaff VA Medical Center (VAMC) in Spokane, Washington. Your letter also requests that we review the VAMC's compliance for suicide prevention training and a specific allegation of substandard care. Enclosed is the result of reviews, *Healthcare Inspection – Emergency Department, Mental Health Service, and Suicide Prevention Training Concerns, Mann-Grandstaff VA Medical Center, Spokane, Washington.*

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 15 2016

The Honorable Richard Blumenthal
U.S. Senate
Washington, DC 20510

Dear Senator Blumenthal:

This is in response to an October 29, 2015, letter from you and Senator Tammy Baldwin requesting a review to determine whether the process and system by which VA shares information with non-VA personnel for purposes of assisting veterans with their claims for service-connection disabilities is adequate to safeguard veterans' personally identifiable information (PII). You shared background information regarding an incident by the Wisconsin Department of Veterans Affairs and the use of VA systems. Enclosed is the result of our review, *Review of Alleged Breach of Privacy and Confidentiality at VBA's Milwaukee VARO*.

A similar response is being sent to Senator Baldwin. Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 15 2016

The Honorable Tammy Baldwin
U.S. Senate
Washington, DC 20510

Dear Senator Baldwin:

This is in final response to an October 29, 2015, letter from you and Senator Richard Blumenthal requesting a review to determine whether the process and system by which VA shares information with non-VA personnel for purposes of assisting veterans with their claims for service-connection disabilities is adequate to safeguard veterans' personally identifiable information (PII). You shared background information regarding an incident by the Wisconsin Department of Veterans Affairs and the use of VA systems. Enclosed is the result of our review, *Review of Alleged Breach of Privacy and Confidentiality at VBA's Milwaukee VARO.*

A similar response is being sent to Senator Blumenthal. Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 15 2016

The Honorable David Young
Member, United States House
of Representatives
601 E. Locust Street, Suite 204
Des Moines, Iowa 50309

Dear Congressman Young:

This is in response to your August 22, 2016 letter on behalf of (b)(6) who requested information about the status of his complaint to the Office of Inspector General (OIG) Hotline. The VA Congressional Liaison Service referred your letter to the OIG on August 24, 2016.

We searched the Hotline records and found one electronic submission from (b)(6) The allegations relates to his assertion that the VA failed to acknowledge a diagnosis from a non-VA provider and therefore has not provided him with adequate medical care. Since (b)(6) submitted his complaint through the internet, he would have received an automatic response as to what to expect next from the OIG. Enclosed is the current version of the automatic response. The original submission was in April 2016, so the version that went out may have been somewhat different as we do update and clarify language in the response from time to time. (b)(6) should continue to work with the Patient Advocate at the Iowa City VA Health Care System where he is receiving care regarding his concerns.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 15 2016

The Honorable Thomas J. Rooney
Member, United States House
of Representatives
226 Taylor Street, Suite 230
Punta Gorda, Florida 33950

Dear Congressman Rooney:

This is in response to your July 20, 2016 letter on behalf of (b)(6) who filed a complaint with the VA Office of Inspector General (OIG) Hotline concerning a fee allegedly assessed to his cousin, (b)(6) by an individual who assisted her with her application for VA benefits and purportedly offered an "expedited VA application service" in exchange for a fee of one month's benefits totaling $1,113. (b)(6) questioned the legality and integrity of this practice because he alleged the service provided was not expedited and could have been performed free of charge through other avenues.

Our records show that (b)(6) contacted the OIG regarding this matter on three occasions between April and July 2016. Without further evidence of (b)(6) Power of Attorney status for (b)(6) consent to release information relative to her VA claim file to (b)(6) we are precluded by from discussing the details of (b)(6) VA claim file. 38 U.S.C. Section 5701 prohibits, with limited exceptions, the disclosure of any files, records, reports, and other papers and documents pertaining to any VA claim (e.g. medical or benefits) except to the individual to whom the record pertains or the individual's authorized agent or representative.

However, we would like to inform (b)(6) that VA's Office of General Counsel (OGC) is the office responsible for reviewing complaints regarding potentially illegal or unethical behavior by individuals assisting with VA benefits claims. OGC maintains a public website with valuable information regarding this topic, which is available at: http://www.va.gov/ogc/accreditation.asp. Complaints regarding unlawful activities, misconduct, or incompetent representation by a VA-accredited individual may be submitted to:

Department of Veterans Affairs
Office of the General Counsel (022D)
810 Vermont Avenue, NW
Washington, DC 20420

Fax: (202) 273-0197
Email: ogcaccreditationmailbox@va.gov

Alternatively, (b)(6) may wish to contact the State of Florida Department of Elder Affairs at:

Florida Department of Elder Affairs
4040 Esplanade Way
Tallahassee, Florida 32399

Phone: (850) 414-2000
Fax: (850) 414-2004
Email: information@elderaffairs.org
Online: http://elderaffairs.state.fl.us/doea/aps.php

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 19 2016

The Honorable Jeff Miller
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in response to your recent inquiry on behalf of (b)(6) who raised concerns about VA's actions regarding his late father's benefits and the care provided prior to his father's death. The VA Congressional Liaison Service referred your letter to the VA Office of Inspector General (OIG) on June 23, 2016.

In his letter to your office, (b)(6) requested the OIG investigate the actions of VA employees involved in the processing of his late father's claim for benefits and a misuse determination by VA. (b)(6)'s allegations regarding the actions of VA employees are administrative in nature and would be more appropriately addressed by VA. In addition, if (b)(6) feels the misuse determination is incorrect, he should work with VA to either challenge that determination or request a waiver.

We will initiate an external referral to the Director of the VA Sunshine Health Care Network, who has managerial oversight of the Orlando VA Medical Center on some issues related to the care provided to (b)(6)'s father. Once we receive and review the Director's response, we will determine whether relevant privacy and confidentiality statutes allow us to release the results to you. In the meantime, it would be helpful if (b)(6) could sign the enclosed release form and provide documentation that he is next of kin.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 20 2016

The Honorable Ron Johnson
Chairman
Committee on Homeland Security
and Governmental Affairs
U.S. Senate
Washington, DC 20510

Dear Mr. Chairman:

This is in response to your September 8, 2016 letter requesting a review of allegations related to staffing shortages at the Mental Health Clinic at the Tomah VA Medical Center. We have already gathered information on this matter and have requested additional information from VA. We will assess all the information and determine our next steps based on our analysis of the matter.

Your September 8th letter also references a veteran who recently committed suicide after allegedly being turned away for care at the Tomah VA Medical Center. We understand that VA officials have briefed your staff on the care provided to this veteran. As part of our assessment, we will also take into consideration information we obtain about the care provided to this veteran.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 20 2016

The Honorable Michael Bennet
U.S. Senate
Washington, DC 20510

Dear Senator Bennet:

This is in response to your August 15, 2016 letter regarding allegations that the Denver VA Regional Office (VARO) failed to accommodate disabled veteran employees at the Denver VARO.

The Office of Inspector General (OIG) released a report on August 23, 2016, *Veterans Benefits Administration – Administrative Investigation Misuse of Official Time Denver Regional Office, Lakewood, Colorado*, that the VA's Office of Accountability Review (OAR) is reviewing regarding leadership at the Denver VARO. In an effort to be of assistance, we have forwarded your correspondence to the OAR. In addition to the OAR, there are other avenues internal and external of VA to address these allegations including organizations that can provide administrative and legal remedies. These included the VA's Office of Resolution Management, the U.S. Office of Special Counsel, the U.S. Equal Employment Opportunities Council, and the Merit Systems Protection Board. Enclosed is a listing of contact information for each of these organizations as well as brief description.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

Copy to: Mr. Michael Culpepper, Director
VA Office of Accountability Review

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 20 20

The Honorable Tammy Baldwin
United States Senator
633 W. Wisconsin Ave, Suite 1920
Milwaukee, Wisconsin 53203

Dear Senator Baldwin:

This is in response to your September 9, 2016 letter requesting an investigation in the services and care provided to (b)(6) by VA at various VA facilities in Wisconsin. It is our understanding that your staff has been briefed by VA on this matter and information that could be shared under the Privacy Act has been shared.

In a potentially related matter, we are gathering information involving staffing issues at the Tomah VA Medical Center. Once that information is reviewed and analyzed, we will determine our next steps.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 21 2016

The Honorable Mike Coffman
United States House of Representatives
Washington, DC 20515

Dear Congressman Coffman:

This is in final response to your April 6, 2015 letter regarding the Office of Inspector General's review of the construction of the replacement Denver VA Medical Center. Enclosed is the result of our review, *Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System.*

(b)(6) and I toured the construction site in June 2016 to review the status of the construction and to understand better the complexity of issues associated with a major capital asset project of this scope.

The OIG's review identified major points of failure that encompass a series of questionable business decisions by VA senior officials concerning planning and design, construction, acquisition, and change order issues. Congress appropriated $800 million between 2004 and 2012 for land acquisition, design, construction, and consult services. However, 2015 project estimates place the final cost at approximately $1.675 billion, or more than twice VA's fiscal year 2009 approved $800 million project budget. VA's 2009 acquisition plan initially estimated construction would be finished in 2013. The project is estimated to be completed in mid to late 2018, or almost 20 years after VA identified the need to replace and expand its aging facility in Denver.

A similar letter is being sent to Congresswoman Kathleen Rice.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 21 2016

The Honorable Mark Takano
Acting Ranking Member
Committee on Veterans' Affairs
United States House of Representatives
Washington, DC 20515

Dear Congressman Takano:

This is in final response to an inquiry from minority staff of the House Committee on Veterans' Affairs regarding the Office of Inspector General's review of the construction of the replacement Denver VA Medical Center. Enclosed is the result of our review, *Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System.*

Deputy Inspector General Linda A. Halliday and I toured the construction site in June 2016 to review the status of the construction and to understand better the complexity of issues associated with a major capital asset project of this scope.

The OIG's review identified major points of failure that encompass a series of questionable business decisions by VA senior officials concerning planning and design, construction, acquisition, and change order issues. Congress appropriated $800 million between 2004 and 2012 for land acquisition, design, construction, and consult services. However, 2015 project estimates place the final cost at approximately $1.675 billion, or more than twice VA's fiscal year 2009 approved $800 million project budget. VA's 2009 acquisition plan initially estimated construction would be finished in 2013. The project is estimated to be completed in mid to late 2018, or almost 20 years after VA identified the need to replace and expand its aging facility in Denver.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 21 2016

The Honorable Ed Perlmutter
United States House of Representatives
Washington, DC 20515

Dear Congressman Perlmutter:

This is in final response to your July 10, 2015 letter regarding the Office of Inspector General's review of the construction of the replacement Denver VA Medical Center. Enclosed is the result of our review, *Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System*.

Deputy Inspector General Linda A. Halliday and I toured the construction site in June 2016 to review the status of the construction and to understand better the complexity of issues associated with a major capital asset project of this scope.

The OIG's review identified major points of failure that encompass a series of questionable business decisions by VA senior officials concerning planning and design, construction, acquisition, and change order issues. Congress appropriated $800 million between 2004 and 2012 for land acquisition, design, construction, and consult services. However, 2015 project estimates place the final cost at approximately $1.675 billion, or more than twice VA's fiscal year 2009 approved $800 million project budget. VA's 2009 acquisition plan initially estimated construction would be finished in 2013. The project is estimated to be completed in mid to late 2018, or almost 20 years after VA identified the need to replace and expand its aging facility in Denver.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 21 2016

The Honorable Jeff Miller
Chairman
Committee on Veterans' Affairs
United States House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in final response to your request of March 2015 that the Office of Inspector General conduct a review of the construction of the replacement Denver VA Medical Center. Enclosed is the result of our review, *Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System.*

Deputy Inspector General Linda A. Halliday and I toured the construction site in June 2016 to review the status of the construction and to understand better the complexity of issues associated with a major capital asset project of this scope.

The OIG's review identified major points of failure that encompass a series of questionable business decisions by VA senior officials concerning planning and design, construction, acquisition, and change order issues. Congress appropriated $800 million between 2004 and 2012 for land acquisition, design, construction, and consult services. However, 2015 project estimates place the final cost at approximately $1.675 billion, or more than twice VA's fiscal year 2009 approved $800 million project budget. VA's 2009 acquisition plan initially estimated construction would be finished in 2013. The project is estimated to be completed in mid to late 2018, or almost 20 years after VA identified the need to replace and expand its aging facility in Denver.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 21 2016

The Honorable Richard Blumenthal
Ranking Member
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Senator Blumenthal:

This is in final response to your April 16, 2015 letter requesting that the Office of Inspector General review the construction of the replacement Denver VA Medical Center. Enclosed is the result of our review, *Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System.*

Deputy Inspector General Linda A. Halliday and I toured the construction site in June 2016 to review the status of the construction and to understand better the complexity of issues associated with a major capital asset project of this scope.

The OIG's review identified major points of failure that encompass a series of questionable business decisions by VA senior officials concerning planning and design, construction, acquisition, and change order issues. Congress appropriated $800 million between 2004 and 2012 for land acquisition, design, construction, and consult services. However, 2015 project estimates place the final cost at approximately $1.675 billion, or more than twice VA's fiscal year 2009 approved $800 million project budget. VA's 2009 acquisition plan initially estimated construction would be finished in 2013. The project is estimated to be completed in mid to late 2018, or almost 20 years after VA identified the need to replace and expand its aging facility in Denver.

A similar letter is being sent to Chairman Isakson.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 21 2016

The Honorable Kathleen Rice
United States House of Representatives
Washington, DC 20515

Dear Congresswoman Rice:

This is in final response to your April 6, 2015 letter regarding the Office of Inspector General's review of the construction of the replacement Denver VA Medical Center. Enclosed is the result of our review, *Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System.*

Deputy Inspector General Linda A. Halliday and I toured the construction site in June 2016 to review the status of the construction and to understand better the complexity of issues associated with a major capital asset project of this scope.

The OIG's review identified major points of failure that encompass a series of questionable business decisions by VA senior officials concerning planning and design, construction, acquisition, and change order issues. Congress appropriated $800 million between 2004 and 2012 for land acquisition, design, construction, and consult services. However, 2015 project estimates place the final cost at approximately $1.675 billion, or more than twice VA's fiscal year 2009 approved $800 million project budget. VA's 2009 acquisition plan initially estimated construction would be finished in 2013. The project is estimated to be completed in mid to late 2018, or almost 20 years after VA identified the need to replace and expand its aging facility in Denver.

A similar letter is being sent to Congressman Mike Coffman.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 21 2016

The Honorable Ann Kirkpatrick
United States House of Representatives
Washington, DC 20515

Dear Congresswoman Kirkpatrick:

This is in final response to your inquiry regarding the Office of Inspector General's review of the construction of the replacement Denver VA Medical Center. Enclosed is the result of our review, *Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System.*

Deputy Inspector General Linda A. Halliday and I toured the construction site in June 2016 to review the status of the construction and to understand better the complexity of issues associated with a major capital asset project of this scope.

The OIG's review identified major points of failure that encompass a series of questionable business decisions by VA senior officials concerning planning and design, construction, acquisition, and change order issues. Congress appropriated $800 million between 2004 and 2012 for land acquisition, design, construction, and consult services. However, 2015 project estimates place the final cost at approximately $1.675 billion, or more than twice VA's fiscal year 2009 approved $800 million project budget. VA's 2009 acquisition plan initially estimated construction would be finished in 2013. The project is estimated to be completed in mid to late 2018, or almost 20 years after VA identified the need to replace and expand its aging facility in Denver.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 21 2016

The Honorable Michael F. Bennet
United States Senate
Washington, DC 20510

Dear Senator Bennet:

This is in final response to your April 23, 2014 letter requesting the Office of Inspector General's review of the construction of the replacement Denver VA Medical Center. Enclosed is the result of our review, *Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System.*

Deputy Inspector General Linda A. Halliday and I toured the construction site in June 2016 to review the status of the construction and to understand better the complexity of issues associated with a major capital asset project of this scope.

The OIG's review identified major points of failure that encompass a series of questionable business decisions by VA senior officials concerning planning and design, construction, acquisition, and change order issues. Congress appropriated $800 million between 2004 and 2012 for land acquisition, design, construction, and consult services. However, 2015 project estimates place the final cost at approximately $1.675 billion, or more than twice VA's fiscal year 2009 approved $800 million project budget. VA's 2009 acquisition plan initially estimated construction would be finished in 2013. The project is estimated to be completed in mid to late 2018, or almost 20 years after VA identified the need to replace and expand its aging facility in Denver.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 21 2016

The Honorable Johnny Isakson
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This is in final response to your April 16, 2015 letter requesting that the Office of Inspector General review the construction of the replacement Denver VA Medical Center. Enclosed is the result of our review, *Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System.*

Deputy Inspector General Linda A. Halliday and I toured the construction site in June 2016 to review the status of the construction and to understand better the complexity of issues associated with a major capital asset project of this scope.

The OIG's review identified major points of failure that encompass a series of questionable business decisions by VA senior officials concerning planning and design, construction, acquisition, and change order issues. Congress appropriated $800 million between 2004 and 2012 for land acquisition, design, construction, and consult services. However, 2015 project estimates place the final cost at approximately $1.675 billion, or more than twice VA's fiscal year 2009 approved $800 million project budget. VA's 2009 acquisition plan initially estimated construction would be finished in 2013. The project is estimated to be completed in mid to late 2018, or almost 20 years after VA identified the need to replace and expand its aging facility in Denver.

A similar letter is being sent to Senator Blumenthal.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 22 2016

The Honorable Mazie K. Hirono
United States Senate
Washington, DC 20510

Dear Senator Hirono:

This is in final response to your August 6, 2015 request that the Office of Inspector General review select aspects of the VA Pacific Islands Health Care System (VAPIHCS), including access to care, travel benefits, cultural sensitivity, outreach and care for homeless veteran patients, and mental health care. Your letter also requested that we review the Veterans Health Administration's 6-point plan to address capacity and access to care within VAPIHCS primary care clinics. Enclosed is the result of our review, *Healthcare Inspection – Summarization of Select Aspects of the VA Pacific Islands Health Care System, Honolulu, Hawaii.*

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 22 2016

(b)(6)

Dear (b)(6)

On the occasion of your retirement, please accept my sincere appreciation for a career dedicated to public service and America's veterans. The VA Office of Inspector General has been most fortunate that you chose to spend your 35-year Federal career with us, making important contributions to the OIG's oversight of the Department of Veterans Affairs as an Investigative and Administrative Coordinator in the Office of Investigations in the Chicago, Illinois Field Office. The OIG's success helping VA deliver on its promises to our veterans would not be possible without the dedication and talent of people like you.

You have my best wishes for a happy and fulfilling retirement. Godspeed!

Sincerely,

MICHAEL J. MISSAL

VA | U.S. Department of Veterans Affairs

Inspector General
Washington DC 20420

SEP 28 2016

The Honorable Mike Coffman
Member, United States House
of Representatives
Cherry Creek Place IV, Suite 305
3300 South Parker Road
Aurora, Colorado 80014

Dear Congressman Coffman:

This is in response to your September 13, 2016 letter on behalf of (b)(6) who alleges there have been prohibited personnel actions taken against her payroll account. The VA Congressional Liaison Service referred your letter to the VA Office of Inspector General (OIG) on September 15, 2016.

We note from the documentation submitted and a search of our records that (b)(6) has reported this concern to the OIG Hotline over a dozen times in 2016. Based on the information provided by (b)(6) Hotline staff determined these personnel actions were not a matter for OIG review. In an effort to be of assistance, staff confirmed to (b)(6) that she should continue to work with her human resources service providers at VA.

The OIG does not accept complaints on personnel matters, such as whistleblower reprisal, that can be addressed in other legal or administrative forums. (b)(6) may also contact the U.S. Office of Special Counsel (OSC), a separate Federal agency with authority to review allegations of prohibited personnel practices, if she thinks these payroll changes were done in retaliation for whistleblowing. OSC can be reached at:

U.S. Office of Special Counsel
1730 M. Street, NW, Suite 218
Washington, DC 20036
1-800-872-9855

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

VA | U.S. Department of Veterans Affairs

Inspector General
Washington DC 20420

SEP 28 2016

The Honorable Dave Loebsack
United States House of Representatives
Washington, DC 20515

Dear Congressman Loebsack:

This is in response to your August 2, 2016 letter requesting that the Office of Inspector General (OIG) review the psychiatric care provided by the Iowa City VA Medical Center in Iowa City, Iowa.

As we have discussed with your staff, the circumstances regarding (b)(3):38 U.S.C. 5701 s suicide are now under review by the OIG's Office of Healthcare Inspections. Upon completion of our review, we will make every effort to share whatever information we can in accordance with applicable law. We have also requested that your staff provide information related to the statement in your letter that you have reports of other veterans being turned away from the Iowa City VA Medical Center, but we have not yet received any additional information. We would appreciate any details your office can provide on these reports.

We also would draw your attention to VA's recent report, "Suicide Among Veterans and Other Americans 2001-2014" containing wide-ranging research into suicide in the veteran population. We hope that our review of (b)(3):38 U.S.C 5701 's care may help augment the information in the VA's report to enable policymakers and healthcare providers to help better serve at-risk veteran populations.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 29 2016

(b)(6)

Dear (b)(6)

On the occasion of your retirement, please accept my sincere appreciation for a career dedicated to public service and America's veterans. The VA Office of Inspector General has been most fortunate that you chose to spend the last 7 years of your 15-year Federal career with us, making important contributions to the OIG's oversight of the Department of Veterans Affairs as a Health System Specialist in the Denver Healthcare Inspections Office in Colorado. The OIG's success helping VA deliver on its promises to our veterans would not be possible without the dedication and talent of people like you.

You have my best wishes for a happy and fulfilling retirement. Godspeed!

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 29 2016

The Honorable H. Morgan Griffith
Member, United States House
of Representatives
323 West Main Street
Abingdon, VA 24210

Dear Congressman Griffith:

This is in final response to an April 29, 2016 request from your staff on behalf of (b)(6) who has concerns about the care received by her late son, (b)(3):38 U.S.C. 5701 at the James H. Quillen VA Medical Center in Mountain Home, Tennessee (Mountain Home VAMC). The VA Congressional Liaison Service referred your letter to the VA Office of Inspector General (OIG) on June 1, 2016.

We previously advised you on July 15, 2016, that we had initiated an external referral to the Director of the VA Healthcare System Network, who has managerial oversight of the Mountain Home VAMC, to review the cancellation of the consult for non-VA oncology services. Enclosed are the redacted responses provided from the Director's office. We redacted information in accordance with exemption (b)(6) of the Freedom of Information Act, which authorizes the withholding of information that, if disclosed, would invade another individual's personal privacy. Based on these responses, we have closed our inquiry.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

VA | U.S. Department of Veterans Affairs

Inspector General
Washington DC 20420

OCT 0 2016

The Honorable Mike Coffman
United States House of Representatives
Washington, DC 20515

Dear Congressman Coffman:

This is in response to your September 21, 2016 letter regarding the Office of Inspector General's (OIG) recent report, *Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System*, and (b)(6) statements regarding the project's cost as detailed in the review.

As discussed in our report, (b)(6) testified before the House Committee on Veterans' Affairs (HVAC), Subcommittee on Oversight and Investigations (O&I) in May 2013 and April 2014. Questions at both hearings directed at (b)(6) focused, in part, on whether VA was within the amounts appropriated to construct the replacement Denver VA Medical Center and whether the project was exceeding the contracted-for price.

Although (b)(6) possessed information that the construction project was exceeding the contracted-for price, on both occasions when he testified before Congress, VA was maintaining that Kiewit-Turner (KT), the contractor, was contractually bound to complete the project within the ceiling price of $610 million. There was litigation over this issue, and VA lost this argument when the Civilian Board of Contract Appeals rendered its final decision on December 9, 2014 relieving Kiewit-Turner from performing under the contract. (b)(6) statements at both hearings, and (b)(6) testimony at the March 25, 2014 HVAC O&I hearing, was not inconsistent with VA's position that KT was contractually bound to complete the project within the ceiling price amount, and therefore no additional funds from Congress would be needed at that time.

Additionally, (b)(6) retired on (b)(6) This was prior to the commencement of our review of the construction project. As such, OIG staff did not interview him and other VA senior executives who were no longer employed at the time of the review, but rather utilized sworn statements from the Administrative Investigation Board, other documents obtained from VA, and interviews of VA employees in conducting our work. For a statement to be false or perjurious, there must be evidence the witness had a willful intent to deceive. As we did not interview (b)(6) we do not have evidence of his intent when he responded to questions regarding the project's costs at the hearings.

It should be noted that the OIG has a close and productive relationship with the Department of Justice (DOJ). Our staffs work together regularly to pursue criminal and civil actions across the Nation. For example, in fiscal year 2016, in partnership with DOJ, our work led to millions of dollars in *False Claims Act* and health care fraud settlements. We also worked with DOJ to obtain jail sentences for individuals who stole from the Government. Our strong relationship with DOJ has been a significant driver of our ability to conduct oversight and stewardship of VA programs and funds.

We are aware that the House Committee on Veterans' Affairs wrote to Attorney General Loretta Lynch on September 22, 2016 requesting that DOJ conduct a criminal investigation into (b)(6)' testimony regarding the project's cost. We will provide any assistance and information DOJ may require in their review.

Deputy Inspector General Linda A. Halliday and I toured the construction site in June 2016 to review the status of the construction and to understand better the complexity of issues associated with a major capital asset project of this scope. We will continue to conduct rigorous oversight over VA's non-recurring maintenance, and major and minor construction program.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

VA | U.S. Department of Veterans Affairs

Inspector General
Washington DC 20420

OCT 6 2016

The Honorable Kathleen Rice
United States House of Representatives
Washington, DC 20515

Dear Congresswoman Rice:

This is in response to your September 23, 2016 letter regarding the Office of Inspector General's (OIG) *Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System* and (b)(6) statements regarding the project's cost as detailed in the review. I greatly appreciate you taking the time on September 21, 2016 for OIG staff to brief you on the review.
As discussed in our report, (b)(6) testified before the House Committee on Veterans' Affairs (HVAC), Subcommittee on Oversight and Investigations (O&I) in May 2013 and April 2014. Questions at both hearings directed at (b)(6) focused, in part, on whether VA was within the amounts appropriated to construct the replacement Denver VA Medical Center and whether the project was exceeding the contracted-for price.

Although (b)(6) possessed information that the construction project was exceeding the contracted-for price, on both occasions when he testified before Congress, VA was maintaining that Kiewit-Turner (KT), the contractor, was contractually bound to complete the project within the ceiling price of $610 million. There was litigation over this issue, and VA lost this argument when the Civilian Board of Contract Appeals rendered its final decision on December 9, 2014 relieving Kiewit-Turner from performing under the contract. (b)(6) statements at both hearings, and (b)(6) testimony at the March 25, 2014 HVAC O&I hearing, was not inconsistent with VA's position that KT was contractually bound to complete the project within the ceiling price amount, and therefore no additional funds from Congress would be needed at that time.

Additionally, (b)(6) retired on (b)(6) This was prior to the commencement of our review of the construction project. As such, OIG staff did not interview him and other VA senior executives who were no longer employed at the time of the review, but rather utilized sworn statements from the Administrative Investigation Board, other documents obtained from VA, and interviews of VA employees in conducting our work. For a statement to be false or perjurious, there must be evidence the witness had a willful intent to deceive. As we did not interview (b)(6) we do not have evidence of his intent when he responded to questions regarding the project's costs at the hearings.

It should be noted that the OIG has a close and productive relationship with the Department of Justice (DOJ). Our staffs work together regularly to pursue criminal and civil actions across the Nation. For example, in fiscal year 2016, in partnership with DOJ, our work led to millions of dollars in *False Claims Act* and health care fraud settlements. We also worked with DOJ to obtain jail sentences for individuals who stole from the Government. Our strong relationship with DOJ has been a significant driver of our ability to conduct oversight and stewardship of VA programs and funds.

We are aware that the House Committee on Veterans' Affairs wrote to Attorney General Loretta Lynch on September 22, 2016 requesting that DOJ conduct a criminal investigation into (b)(6) testimony regarding the project's cost. We will provide any assistance and information DOJ may require in their review.

Deputy Inspector General Linda A. Halliday and I toured the construction site in June 2016 to review the status of the construction and to understand better the complexity of issues associated with a major capital asset project of this scope. We will continue to conduct rigorous oversight over VA's non-recurring maintenance, and major and minor construction program.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

VA | U.S. Department of Veterans Affairs

Inspector General
Washington DC 20420

OCT -4 2016

The Honorable Jeff Flake
United States Senator
2200 East Camelback Road, Ste. 120
Phoenix, Arizona 85016

Dear Senator Flake:

This is in response to your September 12, 2016 letter on behalf of (b)(6) (b)(6) who alleges that aspects of his disability claim for hearing loss and depression have been mishandled by the Board of Veterans Appeals (BVA) through falsification of his medical records. He requested an investigation of the circumstances around BVA's lack of attention to this issue.

The Office of Inspector General (OIG) Hotline was contacted by (b)(6) via email regarding this matter on May 1 and June 2, 2016. All individuals who submit electronic complaints to the OIG Hotline and provide contact information receive an automated response confirming receipt of the complaint and stating complainants will only be contacted again if the OIG opened a case or needed additional information. A copy of the current version of this correspondence is enclosed.

The OIG does not intervene in the determination of veterans' benefits rating decisions or appeals. Decisions on individual benefits claims are the responsibility of the Veterans Benefits Administration and BVA. (b)(6) should continue to work with BVA to determine his appeal rights.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

OCT 5 2016

The Honorable Bill Nelson
United States Senator
225 East Robinson Street
Suite 410
Orlando, Florida 32801

Dear Senator Nelson:

This is in response to your September 2, 2016 letter on behalf of (b)(6) who alleges that VA does not have adequate treatment for people with his condition. He also alleges that his VA physician at the James A. Haley Veterans Hospital in Tampa, Florida, was not timely in sending a letter to the Mayo Clinic to support his request for specialized treatment.

Based on our review of (b)(6) medical record, our Office of Healthcare Inspection, which is staffed by physicians, nurses, and other clinical staff, concluded that his treating physician provided ongoing and comprehensive care. We note from the record, that (b)(6) care team offered him care over the phone to accommodate his difficulty leaving his home. Accordingly, we have decided not to pursue any further action on this matter as the record indicates that (b)(6) clinical needs have been met and we did not see any evidence of unreasonable delays in sending a letter to the Mayo Clinic.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

OCT -4 2016

The Honorable Jeff Flake
United States Senator
2200 E Camelback Road, Suite 120
Phoenix, Arizona 85016

Dear Senator Flake:

This is in final response to an email inquiry from your staff on April 15, 2016 on behalf of (b)(6) regarding the treatment his late father, (b)(3) 38 U.S.C. 5701 received at the Southern Arizona VA Health Care System.

On July 20, 2016 we initiated an external referral to the Network Director of the VA Southwest Health Care Network, who has managerial oversight of the Southern Arizona VA Health Care System in Tucson, Arizona. We have received and reviewed the Director's response, and we have closed our inquiry. Enclosed is a redacted version of the Director's response. We made minimal redactions in accordance with exemption (b)(6) of the Freedom of Information Act, which authorizes the withholding of information that, if disclosed, would invade another individual's personal privacy.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General

801 I (Eye) Street, NW, Suite 1100
Washington, DC 20001

October 13, 2016

Refer To: 2016-00932-IQ-0001

Ms. Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 218
Washington, DC 20036-4505

Dear Ms. Lerner,

The VA Office of Inspector General (VA OIG) received the following allegations regarding potential prohibited personnel practices.

An anonymous source reported preselection in VA's hiring of several GS-14s within the MyVA organization. More specifically, the source alleged that (b)(6) (b)(6) stated that he already had "pre-selected someone for filling this/these positions as well as several of the GS-14 positions" within the VA's Southeast District.

While being interviewed in connection with alleged prohibited personnel practices within the Office of Human Resources and Administration (HRA), (b)(6) (b)(6) (b)(6) also reported having had concerns with MyVA's hiring practices. More specifically, he stated as follows:

> (b)(6) and I were both so concerned...We put three HR people [in MyVA] to keep them away from...potential prohibited personnel practice by people customizing [position descriptions (PDs)] specifically to a person...we first started getting really concerned when the [delegated authority for position classification] was approved by the [Chief of Staff].

The original allegation for which (b)(6) was being interviewed, VA OIG #2014-01540-IQ-0089, was forwarded to you previously under separate cover.

Because these additional allegations implicate potential prohibited personnel practices within the jurisdiction of the Office of Special Counsel, we are also referring them to your agency for action as you deem appropriate. Enclosed are CDs containing the

information we developed for your consideration. The passphrase to open the encrypted files is just as typed: For Official Use Only.

If you have any questions, please contact me at (202) 461-4720.

Respectfully,

Michael J. Missal
Inspector General

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General

801 I (Eye) Street, NW, Suite 1056
Washington, DC 20001

October 13, 2016

Refer To: VA Case No. 2016-0330-IQ-0005
VA OIG Hotline Ref. 2016-30723

Ms. Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 218
Washington, DC 20036-4505

Dear Ms. Lerner,

As a result of a referral from the VA Office of General Counsel (VA OGC), this office opened an administrative investigation into (b)(6) (b)(6) (b)(6) alleged improper operation of a charity while on duty (VA OIG Case No. 2016-0330-IQ-0005). During the resulting audit of (b)(6) use of governmental email and voicemail systems, several communications were identified as being of potential interest to the Office of Special Counsel due to your office's exclusive jurisdiction over Hatch Act violations under 5 CFR 734.102. Additionally, the VA OIG Hotline also received an anonymous telephonic hotline complaint reporting that (b)(6) (b)(6) allegedly engages in partisan political activity while at work (VA OIG Hotline Contact Referral 2016-30723).

Enclosed is information developed by our staff for your consideration and action as you deem appropriate. The enclosed CD contains the information in an encrypted form, and the passphrase to open it is just as typed: For Official Use Only.

If you have any questions, please contact me at (202) 461-4720.

Respectfully,

Michael J. Missal
Inspector General

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General

801 I (Eye) Street, NW, Suite 1100
Washington, DC 20001

October 13, 2016

Refer To: 2014-01540-IQ-0089

Ms. Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 218
Washington, DC 20036-4505

Dear Ms. Lerner,

The VA Office of Inspector General (VA OIG) received an anonymous allegation that current (b)(6) while formerly serving as the (b)(6) (b)(6) "committed a number of prohibited personnel actions and illegal hirings." This matter was previously referred to you under separate cover (VA OIG #2014-01540-IQ-0089).

While conducting that investigation, VA OIG developed evidence that (b)(6) (b)(6) (b)(6) engaged in a possible improper hiring action within VA's Office of Human Resources and Administration. As a result, VA OIG opened an inquiry into (b)(6) hiring of (b)(6) as his GS-14 Executive Assistant, focusing on (b)(6) alleged preselection. (b)(6) has since left the Department for other Federal employment. Therefore, both (b)(6) and (b)(6) have left their prior positions at VA.

As this matter concerns alleged prohibited personnel actions, it is being referred to your office. Enclosed are two identical CDs with the supporting evidence for your consideration and action as you deem appropriate. To open the protected CDs, type the following passphrase just as typed: For Official Use Only

If you have any questions, please contact me at (202) 461-4720.

Respectfully,

Michael J. Missal
Inspector General

Enclosures

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General

801 I (Eye) Street, NW, Suite 1100
Washington, DC 20001

October 13, 2016

Refer To: 2014-01540-IQ-0089

Ms. Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 218
Washington, DC 20036-4505

Dear Ms. Lerner,

The VA Office of Inspector General (VA OIG) received an anonymous allegation that current (b)(6) (b)(6) while formerly serving as the VA (b)(6) "committed a number of prohibited personnel actions and illegal hirings." This matter was previously referred to you under separate cover (VA OIG #2014-01540-IQ-0089).

While conducting that investigation, VA OIG developed evidence that (b)(6) (b)(6) (b)(6) engaged in a possible improper hiring action within VA's Office of Human Resources and Administration. As a result, VA OIG opened an inquiry into (b)(6) hiring of (b)(6) as his GS-14 Executive Assistant, focusing on (b)(6) alleged preselection. (b)(6) has since left the Department for other Federal employment. Therefore, both (b)(6) have left their prior positions at VA.

As this matter concerns alleged prohibited personnel actions, it is being referred to your office. Enclosed are two identical CDs with the supporting evidence for your consideration and action as you deem appropriate. To open the protected CDs, type the following passphrase just as typed: For Official Use Only

If you have any questions, please contact me at (202) 461-4720.

Respectfully,

Michael J. Missal
Inspector General

Enclosures

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

OCT 24 2016

(b)(6)

Dear (b)(6)

On the occasion of your retirement, please accept my sincere appreciation for a career dedicated to public service and America's veterans. The VA Office of Inspector General has been most fortunate that you chose to spend the last 17 years of your 25-year Federal career with us, making important contributions to the OIG's oversight of the Department of Veterans Affairs as a Special Agent in the Office of Investigations in the Newark, New Jersey Field Office. The OIG's success helping VA deliver on its promises to our veterans would not be possible without the dedication and talent of people like you.

You have my best wishes for a happy and fulfilling retirement. Godspeed!

Sincerely,

MICHAEL J. MISSAL

VA | U.S. Department of Veterans Affairs

Inspector General
Washington DC 20420

OCT 19 2016

The Honorable Ron Johnson
United States Senate
Washington, DC 20510

Dear Chairman Johnson:

This is in response to your cosigned September 19, 2016 letter requesting that the Office of Inspector General (OIG) review the alleged use of unofficial wait lists to manage health care for veterans at the Eastern Colorado Health Care System in Denver, Colorado as well as its Golden and Colorado Springs, Colorado Community-Based Outpatient Clinics (CBOC). Additionally, you requested we review the alleged falsification of documents related to the suicide of a veteran waiting for care for Post-Traumatic Stress Disorder at the Colorado Springs CBOC.

The circumstances regarding the alleged document falsification as well as the alleged use of unofficial wait lists are now under review by OIG staff. Upon completion of our review, we will make every effort to share whatever information we can in accordance with applicable law.

We provided a similar response to Senator Gardner under separate cover. Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Copy to: The Honorable Thomas R. Carper
Ranking Member
Committee on Homeland Security and Governmental Affairs

VA | U.S. Department of Veterans Affairs

Inspector General
Washington DC 20420

OCT 19 2016

The Honorable Mike Coffman
United States House of Representatives
Washington, DC 20515

Dear Representative Coffman:

This is in response to your cosigned September 22, 2016 letter requesting that the Office of Inspector General (OIG) provide your office with the results of our review of the alleged use of unofficial wait lists to manage health care for veterans at the Eastern Colorado Health Care System in Denver, Colorado as well as its Golden and Colorado Springs, Colorado Community-Based Outpatient Clinics (CBOC). Additionally, you requested the results of our review of the allegation that documents regarding the suicide of a veteran waiting for care for Post-Traumatic Stress Disorder at the Colorado Springs CBOC have been falsified.

The circumstances regarding the alleged document falsification as well as the alleged use of unofficial wait lists are now under review by OIG staff. Upon completion of our review, we will make every effort to share whatever information we can in accordance with applicable law.

We provided a similar response to Representative Lamborn under separate cover.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

VA | U.S. Department of Veterans Affairs

Inspector General
Washington DC 20420

OCT 19 2016

The Honorable Doug Lamborn
United States House of Representatives
Washington, DC 20515

Dear Representative Lamborn:

This is in response to your cosigned September 22, 2016 letter requesting that the Office of Inspector General (OIG) provide your office with the results of our review of the alleged use of unofficial wait lists to manage health care for veterans at the Eastern Colorado Health Care System in Denver, Colorado as well as its Golden and Colorado Springs, Colorado Community-Based Outpatient Clinics (CBOC). Additionally, you requested the results of our review of the allegation that documents regarding the suicide of a veteran waiting for care for Post-Traumatic Stress Disorder at the Colorado Springs CBOC have been falsified.

The circumstances regarding the alleged document falsification as well as the alleged use of unofficial wait lists are now under review by OIG staff. Upon completion of our review, we will make every effort to share whatever information we can in accordance with applicable law.

We provided a similar response to Representative Coffman under separate cover.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

VA | U.S. Department of Veterans Affairs

Inspector General
Washington DC 20420

OCT 19 2016

The Honorable Michael Bennet
United States Senate
Washington, DC 20510

Dear Senator Bennet:

This is in response to your September 15, 2016 letter requesting that the Office of Inspector General (OIG) review the alleged use of unofficial wait lists to manage health care for veterans at the Eastern Colorado Health Care System in Denver, Colorado as well as its Golden and Colorado Springs, Colorado Community-Based Outpatient Clinics (CBOC).

The circumstances regarding the alleged use of unofficial wait lists are now under review by OIG staff. Additionally, OIG staff will be reviewing the allegation that documents regarding the suicide of a veteran waiting for care for Post-Traumatic Stress Disorder at the Colorado Springs CBOC have been falsified. Upon completion of our review, we will make every effort to share whatever information we can in accordance with applicable law.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

VA | U.S. Department of Veterans Affairs

Inspector General
Washington DC 20420

OCT 19 2016

The Honorable Cory Gardner
United States Senate
Washington, DC 20510

Dear Senator Gardner:

This is in response to your cosigned September 19, 2016 letter requesting that the Office of Inspector General (OIG) review the alleged use of unofficial wait lists to manage health care for veterans at the Eastern Colorado Health Care System in Denver, Colorado as well as its Golden and Colorado Springs, Colorado Community-Based Outpatient Clinics (CBOC). Additionally, you requested we review the alleged falsification of documents related to the suicide of a veteran waiting for care for Post-Traumatic Stress Disorder at the Colorado Springs CBOC.

The circumstances regarding the alleged document falsification as well as the alleged use of unofficial wait lists are now under review by OIG staff. Upon completion of our review, we will make every effort to share whatever information we can in accordance with applicable law.

We provided a similar response to Senator Johnson under separate cover. Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

OCT 17 2016

(b)(6)

Dear (b)(6)

On the occasion of your retirement, please accept my sincere appreciation for a career dedicated to public service and America's veterans. The VA Office of Inspector General has been most fortunate that you chose to spend the last 5 years of your 26-year Federal career with us, making important contributions to the OIG's oversight of the Department of Veterans Affairs as a Special Agent in the Office of Investigations, Criminal Investigation Division in San Francisco, California. The OIG's success helping VA deliver on its promises to our veterans would not be possible without the dedication and talent of people like you.

You have my best wishes for a happy and fulfilling retirement. Godspeed!

Sincerely,

MICHAEL J. MISSAL

Department of Veterans Affairs
Office of Inspector General
Washington, DC 20420

October 14, 2016

(b)(6)
Lakeview Center - Baptist Health Care
1221 W. Lakeview Avenue
Pensacola, FL 32501

Re: Subpoena for Records

Dear Madam:

Accompanying this letter is a Department of Veterans Affairs, Office of Inspector General subpoena calling for the production of certain documents relating to a deceased individual in the custody of the Medical Records Department of the Lakeview Center- Baptist Health Care. The subpoena is returnable at the place, date, and time indicated on the subpoena. The subpoena has been issued pursuant to the authority given to the Inspector General by the Inspector General Act of 1978, 5 U.S.C. App.

(b)(3):38 U.S.C. 5701

The Department of Veterans Affairs Office of Inspector General is conducting oversight regarding the care of [redacted] Evers at Gulf Coast Veterans Health Care System. The completion of this review requires that we obtain and review records in the custody of the Lakeview Center- Baptist Health Care.

Failure to appear at the time and place set forth and as specified in the subpoena will be taken as a failure to comply with the subpoena. In lieu of personal appearance, the requested documents may be provided electronically or by express mail to the following address:

(b)(6)
Bay Pines Office of Healthcare Inspections
10000 Bay Pines Blvd
Building 37, 2nd Floor
Bay Pines, FL 33744

If you can produce the records in electronic format, please contact (b)(6) at (b)(6) or (b)(6) and she will establish a secure portal for sending the documents electronically.

Sincerely,

MICHAEL E. MISSAL
INSPECTOR GENERAL

Enclosures

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

SUBPOENA

TO: CUSTODIAN OF RECORDS

YOU ARE HEREBY COMMANDED TO APPEAR BEFORE

ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS
John David Daigh or his designee

An official of the Office of Inspector General, at **Department of Veterans Affairs, Office of Inspector General, 801 Eye Street NW, Room 1010,**

in the City of **Washington** in the **District of Columbia,**

on the 31ST day of October 2016 at 11:00 a.m. of that day

and you are hereby required to bring with you and produce at said time and place the following information: certified copies of death certificates for the individual(s) identified in Appendix 1.

This information is necessary in the performance of the responsibility of the Inspector General under the Inspector General Act of 1978, 5 U.S.C. App. The Inspector General is authorized to conduct and supervise audits and investigations for the detection and prevention of fraud and abuse in, and the promotion of economy, efficiency, and effectiveness in the administration of, the programs and operations of the DEPARTMENT OF VETERANS AFFAIRS.

IN TESTIMONY WHEREOF, the signature of the Deputy Inspector General of the Office of Inspector General of the DEPARTMENT OF VETERANS AFFAIRS is affixed at Washington, D.C. this 13th day of October 2016.

MICHAEL MISSAL
Inspector General

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

OCT 12 2016

(b)(6)
Ceremonial Activities Division
U.S. Army Military District of Washington J/G-3
103 Third Avenue (Building 42)
Fort McNair, Washington, DC 20319-5058

Dear (b)(6)

Enclosed is a completed DD Form 2536, Request for Armed Forces Participation in Public Events (Non-Aviation), requesting that the Armed Forces Color Guard present the Colors at the Department of Veterans Affairs, Office of Inspector General annual award ceremony on Thursday, December 8, 2016. Last year, the Armed Forces Color Guard participated in our 23rd Annual Inspector General Awards event and their presentation of the Colors was one of the program highlights. We hope that we can count on them again.

Please contact (b)(6) if you have any questions.

Sincerely,

MICHAEL J. MISSAL
Inspector General

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

OCT 6 2016

The Honorable Johnny Isakson
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

To keep VA oversight committees fully informed of the status of Office of Inspector General (OIG) recommendations, we are providing a periodic status report on unimplemented recommendations in OIG reports for the period ending June 30, 2016. There are currently a total of 212 open reports with 1,002 open recommendations. We close an open recommendation when we are confident that VA has met its commitment or that the recommendation is no longer necessary due to changed circumstances. Most are tracking to close within one year of publication, which is our target date for implementation of OIG recommendations.

However, 52 reports containing 137 open recommendations are over one year old. For these reports, we are enclosing:

- A narrative report for the 52 reports and 137 recommendations that have been open more than a year. We summarized the open recommendations for each report by responsible office for implementation (e.g., Veterans Health Administration), the current status for each, and any monetary benefits available from implementation of a recommendation. The total monetary benefit that has yet to be realized is $1,418,900,000. (Attachment A)
- A report listing all 52 reports by OIG report number, issue date, report title, responsible office, the identifying number and text of the open recommendation, and total number of open recommendations for each report. We show report titles in bold italics if the report was requested, or an interest expressed, by the House Veterans' Affairs Committee, Senate Veterans' Affairs Committee, House Appropriations Committee, Senate Appropriations Committee, or the VA Secretary. (Attachment B)

Recommendations in the annual audit reports on the VA information security program required by the *Federal Information Security Management Act of 2002* (FISMA) are tracked separately by OIG's independent auditor and are not included here. Currently, there are 35 open recommendations. OIG's independent auditor will report the status of these recommendations in future FISMA reports.

Copies of these reports are also being provided to Senate Veterans' Affairs Committee Ranking Member Richard Blumenthal, House Veterans' Affairs Committee Chairman Jeff Miller, and House Veterans' Affairs Committee Acting Ranking Member Mark Takano. If you need additional information, please contact (b)(6) (b)(6)

Sincerely,

MICHAEL J. MISSAL

Enclosures

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

OCT 6 2016

The Honorable Richard Blumenthal
Ranking Member
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Senator Blumenthal:

To keep VA oversight committees fully informed of the status of Office of Inspector General (OIG) recommendations, we are providing a periodic status report on unimplemented recommendations in OIG reports for the period ending June 30, 2016. There are currently a total of 212 open reports with 1,002 open recommendations. We close an open recommendation when we are confident that VA has met its commitment or that the recommendation is no longer necessary due to changed circumstances. Most are tracking to close within one year of publication, which is our target date for implementation of OIG recommendations.

However, 52 reports containing 137 open recommendations are over one year old. For these reports, we are enclosing:

- A narrative report for the 52 reports and 137 recommendations that have been open more than a year. We summarized the open recommendations for each report by responsible office for implementation (e.g., Veterans Health Administration), the current status for each, and any monetary benefits available from implementation of a recommendation. The total monetary benefit that has yet to be realized is $1,418,900,000. (Attachment A)
- A report listing all 52 reports by OIG report number, issue date, report title, responsible office, the identifying number and text of the open recommendation, and total number of open recommendations for each report. We show report titles in bold italics if the report was requested, or an interest expressed, by the House Veterans' Affairs Committee, Senate Veterans' Affairs Committee, House Appropriations Committee, Senate Appropriations Committee, or the VA Secretary. (Attachment B)

Recommendations in the annual audit reports on the VA information security program required by the *Federal Information Security Management Act of 2002* (FISMA) are tracked separately by OIG's independent auditor and are not included here. Currently, there are 35 open recommendations. OIG's independent auditor will report the status of these recommendations in future FISMA reports.

Copies of these reports are also being provided to Senate Veterans' Affairs Committee Chairman Johnny Isakson, House Veterans' Affairs Committee Chairman Jeff Miller, and House Veterans' Affairs Committee Acting Ranking Member Mark Takano. If you need additional information, please contact (b)(6) (b)(6)

Sincerely,

MICHAEL J. MISSAL

Enclosures

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

OCT 6 2016

The Honorable Jeff Miller
Chairman
Committee on Veterans' Affairs
United States House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

To keep VA oversight committees fully informed of the status of Office of Inspector General (OIG) recommendations, we are providing a periodic status report on unimplemented recommendations in OIG reports for the period ending June 30, 2016. There are currently a total of 212 open reports with 1,002 open recommendations. We close an open recommendation when we are confident that VA has met its commitment or that the recommendation is no longer necessary due to changed circumstances. Most are tracking to close within one year of publication, which is our target date for implementation of OIG recommendations.

However, 52 reports containing 137 open recommendations are over one year old. For these reports, we are enclosing:

- A narrative report for the 52 reports and 137 recommendations that have been open more than a year. We summarized the open recommendations for each report by responsible office for implementation (e.g., Veterans Health Administration), the current status for each, and any monetary benefits available from implementation of a recommendation. The total monetary benefit that has yet to be realized is $1,418,900,000. (Attachment A)
- A report listing all 42 reports by OIG report number, issue date, report title, responsible office, the identifying number and text of the open recommendation, and total number of open recommendations for each report. We show report titles in bold italics if the report was requested, or an interest expressed, by the House Veterans' Affairs Committee, Senate Veterans' Affairs Committee, House Appropriations Committee, Senate Appropriations Committee, or the VA Secretary. (Attachment B)

Recommendations in the annual audit reports on the VA information security program required by the *Federal Information Security Management Act of 2002* (FISMA) are tracked separately by OIG's independent auditor and are not included here. Currently, there are 35 open recommendations. OIG's independent auditor will report the status of these recommendations in future FISMA reports.

Copies of these reports are also being provided to House Veterans' Affairs Committee Acting Ranking Member Mark Takano, Senate Veterans' Affairs Committee Chairman Johnny Isakson, and Senate Veterans' Affairs Committee Ranking Member Richard Blumenthal. If you need additional information, please contact (b)(6) (b)(6)

Sincerely,

MICHAEL J. MISSAL

Enclosures

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

OCT 6 2016

The Honorable Mark Takano
Acting Ranking Member
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Takano:

To keep VA oversight committees fully informed of the status of Office of Inspector General (OIG) recommendations, we are providing a periodic status report on unimplemented recommendations in OIG reports for the period ending June 30, 2016. There are currently a total of 212 open reports with 1,002 open recommendations. We close an open recommendation when we are confident that VA has met its commitment or that the recommendation is no longer necessary due to changed circumstances. Most are tracking to close within one year of publication, which is our target date for implementation of OIG recommendations.

However, 52 reports containing 137 open recommendations are over one year old. For these reports, we are enclosing:

- A narrative report for the 52 reports and 137 recommendations that have been open more than a year. We summarized the open recommendations for each report by responsible office for implementation (e.g., Veterans Health Administration), the current status for each, and any monetary benefits available from implementation of a recommendation. The total monetary benefit that has yet to be realized is $1,418,900,000. (Attachment A)
- A report listing all 52 reports by OIG report number, issue date, report title, responsible office, the identifying number and text of the open recommendation, and total number of open recommendations for each report. We show report titles in bold italics if the report was requested, or an interest expressed, by the House Veterans' Affairs Committee, Senate Veterans' Affairs Committee, House Appropriations Committee, Senate Appropriations Committee, or the VA Secretary. (Attachment B)

Recommendations in the annual audit reports on the VA information security program required by the *Federal Information Security Management Act of 2002* (FISMA) are tracked separately by OIG's independent auditor and are not included here. Currently, there are 35 open recommendations. OIG's independent auditor will report the status of these recommendations in future FISMA reports.

Copies of these reports are also being provided to House Veterans' Affairs Committee Chairman Jeff Miller, Senate Veterans' Affairs Committee Chairman Johnny Isakson, and Senate Veterans' Affairs Committee Ranking Member Richard Blumenthal. If you need additional information, please contact (b)(6) (b)(6)

Sincerely,

MICHAEL J. MISSAL

Enclosures

VA | U.S. Department of Veterans Affairs

Inspector General
Washington DC 20420

NOV 28 2016

The Honorable Tammy Duckworth
U.S. House of Representatives
Washington, DC 20515

Dear Congresswoman Duckworth:

Thank you for your letter of November 23, 2016 regarding allegations of prohibited personnel practices and other actions taking place in the Consolidated Mail Outpatient Pharmacy (CMOP) Program at the Edward Hines, Jr., VA Hospital in Hines, Illinois.

Per your request, auditors from our Chicago Audit Operations Division will be meeting in the near future with CMOP employees to hear their concerns directly. We will determine our next steps based on our analysis of the information we gather. We will also provide your office with updates during the course of this process.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Department of Veterans Affairs
Office of Inspector General (50)
810 Vermont Avenue, N.W.
Washington, DC 20420

Official Business

The Honorable Hal Rogers
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

10/6/16

Dear Chairman Rogers,

I would like to express my thanks for my stewardship of the FY 2017 budget for the VA Office of Inspector General. Since being sworn in as the Inspector General on May 2, I have been impressed with the OIG's focus on bringing about effective change in VA's programs and operations. The additional resources provided to us in the FY 2017 budget will enable us to increase our rigorous and independent oversight of VA's programs and operations. This will directly impact veterans in a positive way.

Additionally, as the 114th Congress concludes, please accept my sincere thanks for your tenure as Chairman of the House Appropriations Committee and the work you have done on behalf of veterans and all Americans.

Sincerely,

Michael J. Missal

Department of Veterans Affairs
Office of Inspector General (50)
810 Vermont Avenue, N.W.
Washington, DC 20420

Official Business

The Honorable Thad Cochran
Chairman
Committee on Appropriations
U.S. Senate
Washington, DC 20510

Dear Chairman Cochran, 10/6/16

I would like to express my appreciation for your stewardship of the FY 2017 budget for the VA Office of Inspector General. Since being sworn in as Inspector General on May 2, I have been impressed with the OIG staff's focus on bringing about effective change in VA's programs and operations. We greatly appreciate the confidence you have shown in OIG's work with the increase in FY 2017. These additional resources will enable us to increase the rigorous, independent oversight on VA's programs and operations that Congress expects, and that directly impact veterans in a positive manner.

I would welcome the opportunity to discuss further my plans for the OIG when you return in November or at your convenience.

Sincerely,
Michael J. Missal

Department of Veterans Affairs
Office of Inspector General (50)
810 Vermont Avenue, N.W.
Washington, DC 20420

Official Business

The Honorable Barbara Mikulski
Vice Chairwoman
Committee on Appropriations
U.S. Senate
Washington, DC 20510

Dear Vice Chairwoman Mikulski, 10/6/16

I would like to express my thanks for your stewardship of the FY2017 budget for the VA Office of Inspector General. Since being sworn in as the Inspector General on May 2nd I have been impressed with the OIG's focus on bringing about effective change in VA's programs and operations. The additional resources provided to us in the FY2017 budget will enable us to increase our rigorous and independent oversight of VA's programs and operations. This will directly impact veterans in a positive way.

Additionally, as the 114th Congress concludes, please accept my sincere thanks for your years of public service in Congress and the work you have done on behalf of veterans and all Americans.

Sincerely,
Michael J. Missal

Department of Veterans Affairs
Office of Inspector General (50)
810 Vermont Avenue, N.W.
Washington, DC 20420

Official Business

The Honorable Mark Kirk
Chairman
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
U.S. Senate
Washington, DC 20510

10/6/16

Dear Chairman Kirk,

I would like to express my thanks for your stewardship of the FY2017 budget for the VA Office of Inspector General. Since being sworn in as the Inspector General on May 2, I have been impressed with the OIG's focus on bringing about effective change in VA's programs and operations. The additional resources provided to us in the FY2017 budget will enable us to increase our rigorous and independent oversight of VA's programs and operations. This will directly impact veterans in a positive way.

I would welcome the opportunity to discuss further my plans for the OIG when you return in November or at your convenience.

Sincerely,

Michael J. Missal

Department of Veterans Affairs
Office of Inspector General (50)
810 Vermont Avenue, N.W.
Washington, DC 20420

Official Business

The Honorable Charlie Dent
Chairman
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Dent 10/6/16

I would like to express my thanks for your stewardship of the FY 2017 budget for the VA Office of Inspector General. Since being sworn in as the Inspector General on May 2, I have been impressed with the OIG's focus on bringing about effective change in VA's programs and operations. The additional resources provided to us in the FY 2017 budget will enable us to increase our rigorous and independent oversight of VA's programs and operations. This will directly impact veterans in a positive way.

I would welcome the opportunity to discuss further my plans for the OIG when you return in November or at your convenience.

Sincerely,
Michael J. Missal

Department of Veterans Affairs
Office of Inspector General (50)
810 Vermont Avenue, N.W.
Washington, DC 20420

Official Business

The Honorable Jon Tester
Ranking Member
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
U.S. Senate
Washington, DC 20510

10/6/16

Dear Ranking Member Tester,

I would like to express my thanks for your stewardship of the FY2017 Budget for the VA Office of Inspector General. Since being sworn in as Inspector General on May 2, I have been impressed with the OIG's focus on bringing about effective change in VA's programs and operations. The additional resources provided to us in the FY2017 budget will enable us to increase our rigorous and independent oversight of VA's programs and operations. This will directly impact veterans in a positive way.

I would welcome the opportunity to discuss further my plans for the OIG when we meet in November or at your convenience.

Sincerely,

Michael J. Missal

Department of Veterans Affairs
Office of Inspector General (50)
810 Vermont Avenue, N.W.
Washington, DC 20420

Official Business

The Honorable Nita Lowey
Ranking Member
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Ranking Member Lowey, 10/6/16

I would like to express my thanks for your stewardship of the FY2017 budget for the VA Office of Inspector General. Since being sworn in as the Inspector General on May 2, I have been impressed with the OIG's focus on bringing about effective change in VA's programs and operations. The additional resources provided to us in the FY2017 budget will enable us to increase our rigorous and independent oversight of VA's programs and operations. This will ultimately impact veterans in a positive way.

I would welcome the opportunity to discuss further my plans for the OIG when you return in November or at your convenience.

Sincerely,

Michael J. Missal

Department of Veterans Affairs
Office of Inspector General (50)
810 Vermont Avenue, N.W.
Washington, DC 20420

Official Business

The Honorable Sanford Bishop
Ranking Member
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
U.S. House of Representatives
Washington, DC 20515

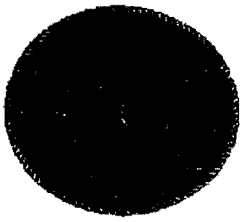
Dear Ranking Member Bishop, 10/6/16

I would like to express my thanks for your stewardship of the FY2017 budget for the VA Office of Inspector General. Since being sworn in as the Inspector General on May 2, I have been impressed with the OIG's focus on bringing about effective change in VA's programs and operations. The additional resources provided to us in the FY2017 budget will enable us to increase our rigorous and independent oversight of VA's programs and operations. This will directly impact veterans in a positive way.

I would welcome the opportunity to discuss further my plans for the OIG when you return in November at your convenience.

Sincerely,

Michael J. Missal



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General

801 I (Eye) Street NW
Washington, DC 20001

November 28, 2016

Refer To: 2016-00932-IQ-0002

Ms. Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 218
Washington, DC 20036-4505

Dear Ms. Lerner,

The VA Office of Inspector General, while conducting another investigation—forwarded to you under separate cover as VA OIG #2016-00932-IQ-0001—discovered email communications between (b)(6) a former VA employee, and VA Senior Officials related to her VA appointment and removal, as well as emails implicating possible whistleblower reprisal. The emails also contain an EEO component against (b)(6)

Our office is discontinuing its inquiry into this matter. In her correspondence, (b)(6) claims to have also contacted your office. We are cognizant of your office's jurisdiction over this matter under 5 USC §1214. To the extent that (b)(6) allegations may also have whistleblower retaliation overtones, your office has jurisdiction over those issues as well.

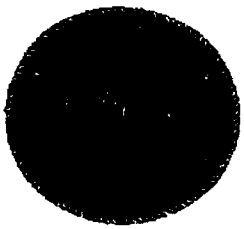
Enclosed is information developed by our staff for your consideration and action as you deem appropriate. The two enclosed CDs contain identical information, and the passphrase to open them is just as typed: For Official Use Only.

If you have any questions, please contact me at (202) 461-4720.

Respectfully,

Michael J. Missal
Inspector General

Enclosures



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General

801 I (Eye) Street NW
Washington, DC 20001

November 28, 2016

Refer To: 2016-03657-DQ-0004

Ms. Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 218
Washington, DC 20036-4505

Dear Ms. Lerner,

The VA Office of Inspector General (VA OIG) received an allegation from a confidential source that (b)(6) while the (b)(6) engaged in a prohibited personnel practice when she influenced an interview panel for a supervisory attorney hiring effort. While conducting an investigation, we developed evidence concerning a potential improper hiring action.

As this matter concerns an alleged prohibited personnel action, we are closing our investigation and referring it to your office for any action you deem appropriate, as we recognize your office's jurisdiction over this matter under 5 USC §1214. Enclosed are CDs containing information we developed for your consideration. The passphrase to open the encrypted files is just as typed: For Official Use Only.

If you have any questions, please contact me at (202) 461-4720.

Respectfully,

Michael J. Missal
Inspector General

Enclosures

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General

801 I (Eye) Street NW
Washington, DC 20001

November 28, 2016

Refer To: 2014-01540-IQ-0005

Ms. Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 218
Washington, DC 20036-4505

Dear Ms. Lerner,

The VA Office of Inspector General (VAOIG) received an allegation from a confidential source that (b)(6) (b)(6) preselected (b)(6) (b)(6) for (b)(6) by providing her preference leading up to and during the hiring process for that position. While conducting an investigation, we developed evidence concerning a potential improper hiring action.

As this matter concerns an alleged prohibited personnel action, we are closing our investigation and referring it to your office for any action you deem appropriate, as we recognize your office's jurisdiction over this matter under 5 USC § 1214. Enclosed are CDs containing information developed for your consideration. The passphrase to open them is just as typed: For Official Use Only.

If you have any questions, please contact me at (202) 461-4720.

Respectfully,

Michael J. Missal
Inspector General

Enclosures

VA | U.S. Department of Veterans Affairs

Inspector General
Washington DC 20420

NOV 29 2016

The Honorable Joni Ernst
United States Senate
Washington, DC 20510

Dear Senator Ernst:

This is in response to your November 16, 2016 letter requesting that the VA Office of Inspector General (OIG) review the health care provided to [(b)(3):38 U.S.C. 5701] by the Veterans Health Administration (VHA) prior to his suicide in November 2016. We have been gathering information on this matter and have requested additional information from VA. We will assess all the information and determine our next steps based on our analysis of the matter. We expect this initial process could take up to two months. Upon completion of our review, we will make every effort to share whatever information we can in accordance with applicable law.

I would like to address other points made in your letter. Your letter references our June 2015 Healthcare Inspection, "Alleged Poor Mental Health Care Resulting in a Patient Death at VA Central Iowa Health Care System – Des Moines, Iowa." I would like to clarify that we did not conclude that the patient did not receive adequate mental health care from VHA. Our inspection did not substantiate that the "patient received poor access to care through the [Emergency Department]" or "that the patient received poor quality of care from [Emergency Department] staff who provided care to the patient in winter 2015..." However, we did substantiate that the facility's case management services were not in compliance with VHA policy. Our inspection made two recommendations, and VA provided information sufficient for the recommendations to be closed in late 2015. A copy of our report is enclosed for your consideration, and it can also be found at: https://www.va.gov/oig/pubs/VAOIG-15-02627-386.pdf.

Your letter also expresses concerns about VA's release of [(b)(3):38 U.S.C. 5701] individually identifiable health information. We believe that VA's Office of General Counsel would be in a better position to explain VA's ability to release [ ] information to members of Congress. However, we note that individually identifiable health information created in the course of treatment at VHA is protected from disclosure not authorized by the privacy provisions enacted in the Health Insurance Portability and Accountability Act. We do not believe that [ ] alleged posting to social media would be considered authorization to release his protected health information or allow VHA to comment upon the information he allegedly posted.

(b)(3):38 U.S.C. 5701

(b)(3):38 U.S.C. 5701

Our mission is to serve veterans by conducting effective oversight over VA programs and operations. We do this, in part, by being independent of VA and making meaningful recommendations that drive economy, efficiency, and effectiveness through VA's programs and operations. However, as a consequence of our statutorily mandated independence, we cannot direct VA operations or mandate their specific policies.

I am also enclosing a copy of our recently released Semi Annual Report that details some of our work on this topic over the last six months. It can also be found at: https://www.va.gov/oig/pubs/sars/vaoig-sar-2016-2.pdf. Our work made numerous recommendations to help improve VA's health care system. We are firmly committed to working with all stakeholders to help improve VA's mental health care operations and to help in the treatment of mental illness nationally.

I would welcome the opportunity to meet with you and discuss this and other work being conducted by the OIG. Thank you for your interest in the OIG.

Sincerely,

MICHAEL J. MISSAL

Enclosures

VA | U.S. Department of Veterans Affairs

Inspector General
Washington DC 20420

NOV 29 2016

The Honorable Charles E. Grassley
United States Senate
Washington, DC 20510

Dear Chairman Grassley:

This is in response to your November 16, 2016 letter requesting that the VA Office of Inspector General (OIG) review the health care provided to (b)(3) 38 U.S.C. 5701 by the Veterans Health Administration prior to his suicide in November 2016.

We have been gathering information on this matter and have requested additional information from VA. We will assess all the information and determine our next steps based on our analysis of the matter. We expect this initial process could take up to two months.

Thank you for your interest in the OIG.

Sincerely,

MICHAEL J. MISSAL

VA | U.S. Department of Veterans Affairs

Inspector General
Washington DC 20420

NOV 29 2016

The Honorable Joni Ernst
United States Senate
Washington, DC 20510

Dear Senator Ernst:

This is in response to your November 10, 2016 letter requesting that the VA Office of Inspector General (OIG) provide an update on the review of health care provided to (b)(3):38 U.S.C. 5701 by the Iowa City VA Medical Center in Iowa City, Iowa prior to his suicide in [redacted] 2016.

(b)(3):38 U.S.C. 5701

As indicated in our letter of August 11, 2016, the circumstances leading to his suicide were under review and that upon completion of the review, we will make every effort to share whatever information we can in accordance with applicable law. On October 24, 2016, your staff requested an update on the review, and OIG staff responded the same day indicating that the review was proceeding and that OIG staff would be in contact to advise when the review was close to publication.

OIG staff are continuing their work on the report. We recognize the importance of this work, and I expect it will be published in the Spring of 2017. The relevant OIG staff are simultaneously working on several significant projects, and we are constantly balancing workloads to ensure reports are published as timely as possible while maintaining their thoroughness and accuracy.

Thank you for your interest in the OIG.

Sincerely,

MICHAEL J. MISSAL

VA | U.S. Department of Veterans Affairs

Inspector General
Washington DC 20420

NOV 28 2016

The Honorable Walter B. Jones
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Jones:

This is in response to your staff's email inquiry of November 15, 2016 regarding our report, "Administrative Investigation – Conduct Prejudicial to the Government and Misuse of Position in the VA Office of General Counsel Washington, DC."

In October 2016, our office provided the U.S. Attorney's Office for the District of Columbia a criminal referral related to (b)(6) misuse of official time and Government resources. We also understand that the Department of Justice has knowledge of the New York Attorney General's investigation into (b)(6) for charity fraud. If you have additional questions about the Department of Justice's interest in this matter please contact them directly.

The two other questions regarding (b)(6) receipt of retirement benefits and potential discipline by his state bar are matters that can be addressed by VA.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 22 2016

(b)(6)

Dear (b)(6)

On the occasion of your retirement, please accept my sincere appreciation for a career dedicated to public service and America's veterans. The VA Office of Inspector General has been most fortunate that you chose to spend the last 30 years of your 32-year Federal career with us, making important contributions to the OIG's oversight of the Department of Veterans Affairs as an Auditor in the Office of Audits and Evaluations in Atlanta, Georgia. The OIG's success helping VA deliver on its promises to our veterans would not be possible without the dedication and talent of people like you.

You have my best wishes for a happy and fulfilling retirement. Godspeed!

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 22 2010

(b)(6)

Dear (b)(6)

On the occasion of your retirement, please accept my sincere appreciation for a career dedicated to public service and America's veterans. The VA Office of Inspector General has been most fortunate that you chose to spend the last 11 years of your 32-year Federal career with us, making important contributions to the OIG's oversight of the Department of Veterans Affairs as an Auditor in the Office of Audits and Evaluations in Bay Pines, Florida. The OIG's success helping VA deliver on its promises to our veterans would not be possible without the dedication and talent of people like you.

You have my best wishes for a happy and fulfilling retirement. Godspeed!

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 22 2016

(b)(6)

Dear (b)(6)

On the occasion of your retirement, please accept my sincere appreciation for a career dedicated to public service and America's veterans. The VA Office of Inspector General has been most fortunate that you chose to spend your 29-year Federal career with us, making important contributions to the OIG's oversight of the Department of Veterans Affairs as an Auditor in the Office of Audits and Evaluations in Bay Pines, Florida. The OIG's success helping VA deliver on its promises to our veterans would not be possible without the dedication and talent of people like you.

You have my best wishes for a happy and fulfilling retirement. Godspeed!

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 22 2016

(b)(6)

Dear (b)(6)

On the occasion of your retirement, please accept my sincere appreciation for a career dedicated to public service and America's veterans. The VA Office of Inspector General has been most fortunate that you chose to spend the last 9 years of your 30-year Federal career with us, making important contributions to the OIG's oversight of the Department of Veterans Affairs as Division Director of the Office of Audits and Evaluations in Dallas, Texas. I am also appreciative and grateful for your efforts in establishing our mentoring and shadowing programs. The OIG's success helping VA deliver on its promises to our veterans would not be possible without the dedication and talent of people like you.

You have my best wishes for a happy and fulfilling retirement. Godspeed!
Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 22 2016

The Honorable French Hill
Member, United States House
of Representatives
1501 N. University Ave., Ste. 150
Little Rock, Arkansas 72202

Dear Congressman Hill:

This is in final response to a June 23, 2016 email from your staff on behalf of (b)(6) who alleged that he was harmed during procedures while an inpatient at the Central Arkansas Veterans Healthcare System - John L. McClellan Memorial Veterans Hospital, in Little Rock, Arkansas, in (b)(6) 2016. We previously advised your office on August 23, 2016 that we would make an external referral to the Network Director of the South Central VA Health Care Network, which has managerial oversight of the facility, on this matter.

We have received and reviewed the Director's response, and we have closed our inquiry. Enclosed is a redacted version of the Director's response. We redacted information in accordance with exemption (b)(6) of the Freedom of Information Act, which authorizes the withholding of information that, if disclosed, would invade another individual's personal privacy.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 18 2016

(b)(6)

Dear (b)(6)

On the occasion of your retirement, please accept my sincere appreciation for a career dedicated to public service and America's veterans. The VA Office of Inspector General has been most fortunate that you chose to spend the last 6 years of your 30-year Federal career with us, making important contributions to the OIG's oversight of the Department of Veterans Affairs as a Benefits Inspector in the Office of Audits and Evaluations in San Diego, California. The OIG's success helping VA deliver on its promises to our veterans would not be possible without the dedication and talent of people like you.

You have my best wishes for a happy and fulfilling retirement. Godspeed!

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 17 2016

The Honorable Tom Udall
United States Senator
120 S. Federal Place, #302
Santa Fe, New Mexico 87501

Dear Senator Udall:

This is in response to your October 1, 2016 letter on behalf of (b)(6) who raised concerns about his ability to receive care from VA facilities outside of New Mexico and his eligibility to be reimbursed by VA for costs associated with emergency non-VA care. We received your letter on October 11, 2016.

We have initiated an external referral to the Network Director of the Desert Pacific Healthcare Network which has managerial oversight of the New Mexico VA Health Care System regarding the non-payment of non-VA services. We have also initiated an external referral to the Network Director of the Sierra Pacifica Network regarding Mr. Dickinson's allegations related to access to California VA facilities. Once we receive and review each response, we will determine whether relevant privacy and confidentiality statutes allow us to release the results to you.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 1 0 2016

The Honorable Marcia L. Fudge
Member, United States House
of Representatives
4834 Richmond Road, Suite 150
Warrensville Heights, Ohio 44128

Dear Congresswoman Fudge:

This is in response to an October 5, 2016 request from your staff on behalf of (b)(6) concerning the Milwaukee, Wisconsin, VA Pension Management Center's (PMC) decision to terminate (b)(6) VA pension and establish an overpayment for funds previously issued to him. We understand that your staff was informed by PMC staff that they were precluded from discussing the details of this matter because of an ongoing investigation by the Office of Inspector General (OIG). As we informed your staff, while the OIG did open an investigation in response to allegations that (b)(6) was in fraudulent receipt of VA pension benefits, our investigation is presently closed. We notified the Milwaukee PMC, in addition to (b)(6) legal counsel, of our decision to close our investigation on September 28, 2016. We encourage (b)(6) to continue working with the Milwaukee PMC to determine if reinstatement of his VA pension and cancellation of the overpayment is appropriate, as the OIG has no role in adjudicating individual VA benefits decisions.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 10 2016

The Honorable Mark Warner
United States Senator
919 East Main Street
Suite 630
Richmond, Virginia 23219

Dear Senator Warner:

This is in response to your October 4, 2016 request on behalf of (b)(6) concerning a suspicious email he received in June 2016 to his VA email account concerning his communications with the U.S. Office of Special Counsel (OSC). The Office of Inspector General's (OIG) Office of Investigations was previously informed of this incident, and it is our understanding that VA information security personnel referred this matter to VA's Network Security Operations Center (NSOC), the office within VA responsible for protecting VA information and networks, for further review. We believe this is the appropriate course of action, for while we agree the incident has not been explained, we do not see indication of criminal activity that would warrant OIG involvement at this time. If the results of NSOC's review suggest otherwise, the OIG will reconsider this matter for review as appropriate. We encourage (b)(6) to continue working with NSOC and OSC on this matter.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 1 0 2016

The Honorable Ryan Costello
Member, United States House
of Representatives
840 North Park Road
Wyomissing, Pennsylvania 19610

Dear Congressman Costello:

This is in final response to a May 20, 2016 request from your staff on behalf of (b)(6) (b)(6) who raised concerns about current anesthesia care practices at the Lebanon VA Medical Center in Lebanon, Pennsylvania. We previously informed you in a letter dated June 17, 2016 that the Office of Inspector General initiated an external referral to the Director of the Veterans Integrated Service Network 4 on this matter, and that once we received and reviewed the Director's response, we would determine whether relevant privacy and confidentiality statutes allow us to release the results to you.

We have now received and reviewed the Director's response, and we have closed our inquiry. Enclosed is a redacted version of the Director's response. We made minimal redactions in accordance with exemption (b)(6) of the Freedom of Information Act, which authorizes the withholding of information that, if disclosed, would invade another individual's personal privacy.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV -7 2016

The Honorable Jeff Flake
United States Senator
2200 East Camelback Road
Suite 120
Phoenix, Arizona 85016

Dear Senator Flake:

This is in final response to your September 11, 2015 letter on behalf of a VA employee who raised a variety of allegations concerning a pharmacist at the Phoenix VA Health Care System (PVAHCS) in Phoenix, Arizona, who was also the subject of a January 2015 VA Administrative Investigative Board (AIB).

We previously informed you in a letter dated March 1, 2016 that we had reviewed the 234-page AIB and supporting documentation, the AIB's recommendations for corrective action, and the actions taken by PVAHCS in response to the AIB's recommendations. While our review determined that available documentation generally did not support the allegation that no meaningful actions were taken as a result of the AIB, we did identify a few matters where we felt it was necessary to obtain clarifying information from VA. As a result, we initiated an external referral to the Director of the VA Southwest Health Care Network, who has managerial oversight of the PVAHCS on this matter.

We have received and reviewed the Director's response, and we have closed our inquiry. Enclosed is a redacted version of the Director's response. We made redactions in accordance with exemption (b)(6) of the Freedom of Information Act, which authorizes the withholding of information that, if disclosed, would invade another individual's personal privacy.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV -7 2016

The Honorable Jeff Flake
United States Senator
2200 East Camelback Road
Suite 120
Phoenix, Arizona 85016

Dear Senator Flake:

This is in response to your August 1, 2016 letter on behalf of (b)(6) who raised concerns about the accuracy of information recorded in a VA Police Service Investigative Report relating to a 2015 incident involving (b)(6) and the VA Police Service at the Phoenix VA Health Care System in Phoenix, Arizona.

Our records indicate that (b)(6) contacted the VA Office of Inspector General (OIG) Hotline regarding this matter on four separate occasions between June 2015 and July 2016. In 2015, OIG criminal investigators reviewed the complaint and determined that the appropriate course of action would be for the OIG to forward (b)(6) concerns to VA's Office of Security and Law Enforcement (OSLE) for whatever action they deemed appropriate. OSLE is the VA office responsible for developing policies, procedures, and standards that govern VA's personal security and law enforcement programs, as well as for conducting internal investigations into allegations of misconduct made against members of the VA Police Service.

We note from the documentation forwarded with (b)(6) complaint that OSLE conducted an investigation into this matter, the results of which were made available to (b)(6) We have reviewed this material, and in the absence of new information from (b)(6) to support his allegations, we see no grounds to warrant an OIG investigation into this matter.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV -4 2016

The Honorable Gus Bilirakis
Member, United States House
of Representatives
7132 Little Road
New Port Richey, Florida 34654

Dear Congressman Bilirakis:

This is in response to your October 19, 2016 letter on behalf of (b)(6) and his concerns about the care VA has provided to him. As we have advised your office in the past, the Office of Inspector General (OIG) has conducted several reviews regarding (b)(6) care and provided your office and other congressional offices with the results of those reviews. The proposed actions that (b)(6) is seeking concerning his physician are outside the scope of the OIG's authority. Enforcing disciplinary action is a function solely within the purview of VA and VA must follow a process as dictated by laws and regulations. We suggest that your office contact VA directly on this matter.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV - 4 2016

The Honorable Daniel Webster
Member, United States House
of Representatives
300 W. Plant Street
Winter Garden, Florida 34787

Dear Congressman Webster:

This is in response to your October 20, 2016 letter forwarding correspondence from (b)(6) to the Office of Inspector General (OIG). (b)(6) submitted an appeal to an OIG decision made under the Freedom of Information Act regarding the release of information. As you noted, (b)(6) sent the appeal to the wrong address.

We provided (b)(6) appeal to the OIG's Release of Information Office and although the deadline for submission has passed, they will process the appeal. However, processing the appeal does not indicate that his appeal will be successful; it means that the appeal official will consider the request and make a determination even though the appeal was not received within the 60 days. We will respond directly to (b)(6) designee.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 14 2016

The Honorable Andy Barr
Member, United States House
of Representatives
2709 Old Rosebud Road, Suite 100
Lexington, Kentucky 40509

Dear Congressman Barr:

This is in response to your letter of September 15, 2016 on behalf of (b)(6) who expressed concerns about the care she received at the Lexington VA Medical Center (VAMC) in Lexington, Kentucky.

We have initiated an external referral to the Director of the VA Mid South Healthcare Network, who has managerial oversight of the Lexington VAMC on this matter. Once we receive and review the Director's response, we will determine whether relevant privacy and confidentiality statutes allow us to release the results to you.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV -4 2016

The Honorable Bill Shuster
Member, United States House
of Representatives
310 Penn Street, Suite 200
Hollidaysburg, Pennsylvania 16648

Dear Congressman Shuster:

This is in response to your August 12, 2016 letter on behalf of (b)(6) regarding allegations that VA personnel made improper advances to him during a compensation and pension examination. We received your letter on September 19, 2016 and our staff has been in contact since receipt.

(b)(6) previously contacted the Office of Inspector (OIG) Hotline with similar allegations as well as requesting assistance with his claims denial. We notified him that on the claims decision, the OIG would not get involved and he should proceed with the appeals process. On the matter related to improper advances, we have initiated a review and due to law enforcement and privacy concerns, no further information is available at this time. It is the Hotline policy not to provide updates on complaints. However, (b)(6) will be notified when the inquiry is completed and how to obtain information regarding the inquiry.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 13 2014

The Honorable Jeff Flake
United States Senator
2200 East Camelback Road
Suite 120
Phoenix, Arizona 85016

Dear Senator Flake:

This is in response to the information you provided to our office, which we received on August 25, 2014, on behalf of (b)(6) relating to safety concerns regarding the Substance Abuse Recovery and Rehabilitation Treatment Program at the Phoenix VA Health Care System (VAHCS) in Phoenix, Arizona, as well as policies and practices within the VA Police Service on both national and local levels.

We initiated inquiries to obtain additional information on these matters with the Director of the VA Southwest Health Care Network, who has managerial oversight of the Phoenix VAHCS, and the Director of VA's Office of Security and Law Enforcement, which is the VA office responsible for developing policies, procedures, and standards that govern VA's personal security and law enforcement programs. We have received and reviewed the Directors' responses, and we have closed our inquiries at this time. However, we are considering this as a topic area for future OIG oversight.

Enclosed are redacted copies of the Directors' responses. We made redactions in accordance with exemptions (b)(5), (b)(6), (b)(7)(E), and (b)(7)(F) of the Freedom of Information Act, which respectively authorize the withholding of privileged communications within or between agencies; information that, if disclosed, would invade another individual's personal privacy; information compiled for law enforcement purposes that would disclose techniques and procedures for law enforcement investigations or prosecutions; and information compiled for law enforcement purposes that could reasonably be expected to endanger the life or physical safety of any individual.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosures

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 0 2 2016

The Honorable Ted Yoho
Member, United States House
of Representatives
35 Knight Boxx Road, Suite 1
Orange Park, Florida 32065

Dear Congressman Yoho:

This is in response to an August 23, 2016 request from your staff on behalf of (b)(6) who has expressed concern that her husband's death may have been attributable to the quality of care he received at the Lake City VA Medical Center (VAMC) in Lake City, Florida. Upon reviewing (b)(6) concerns, in conjunction with her husband's VA medical records, we determined the appropriate course of action for the Office of Inspector General (OIG) would be to initiate an inquiry into (b)(6) care with the Director of the VA Sunshine Healthcare Network, who has managerial oversight of the Lake City VAMC. We received (b)(6) consent to do so on October 26, 2016 through assistance from your staff. Once we receive and review the Director's response, we will determine whether relevant privacy and confidentiality statutes allow us to release the results to you.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 0 2 2016

The Honorable Harry Reid
United States Senator
400 South Virginia Street, Suite 902
Courthouse and Federal Building
Reno, Nevada 89501

Dear Senator Reid:

This is in response to a September 10, 2016 request from your staff on behalf of (b)(6) concerning a construction contractor hired by VA to perform modifications to her home. Specifically, (b)(6) is concerned that the contractor may have received payment for the contracted services despite never having completed the work. We previously informed your staff that, upon reviewing the allegations, we determined the appropriate course of action for the Office of Inspector General would be to initiate an inquiry on (b)(6) behalf with the Director of VA's Loan Guaranty Service on this matter. Once we receive and review the Director's response, we will determine whether relevant privacy and confidentiality statutes allow us to release the results to you.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 0 2 2016

The Honorable Sherrod Brown
United States Senate
Washington, DC 20510

Dear Senator Brown:

This is in response to your July 15, 2016 letter to the Director of the Chillicothe VA Medical Center, in Chillicothe, Ohio, concerning the care provided to (b)(6) (b)(6) The Office of Inspector General (OIG) was copied on the letter. As we previously discussed with your staff, based on subsequent information provided by your staff to the OIG, we believe the appropriate course of action at this time is for the OIG to initiate an inquiry with the Director of the Veterans Integrated Service Network 10, who has managerial oversight of the Chillicothe VAMC, on select aspects of (b)(6) care. Once we receive and review the Director's response, we will determine whether relevant privacy and confidentiality statutes allow us to release the results to you.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 0 2 2016

The Honorable Ken Calvert
Member, United States House
of Representatives
4160 Temescal Canyon Road
Suite 214
Corona, California 92883

Dear Congressman Calvert:

This is in response to your September 29, 2016 letter on behalf of (b)(6) who expressed concerns about possible improprieties taking place within the VA Long Beach Healthcare System Travel Office in Long Beach, California.

Our records show that (b)(6) previously contacted the Office of Inspector General (OIG) Hotline regarding this matter on June 23 and September 16, 2016. In order to determine whether this is a matter warranting further review by the OIG, we have contacted (b)(6) on three occasions to request that he submit additional details concerning these allegations. To date, we do not have a record of receiving the requested information. Our public website contains guidance for VA employees about how to transmit sensitive information to the OIG in a secure manner, which is available at: http://www.va.gov/oig/hotline.

The Office of Inspector General (OIG) does not accept complaints on personnel matters, such as whistleblower reprisal, that can be addressed in other legal or administrative forums. For further assistance, (b)(6) may contact the U.S. Office of Special Counsel (OSC), a separate Federal agency with authority to review allegations of prohibited personnel practices, including reprisal for whistleblowing. OSC can be reached at:

U.S. Office of Special Counsel
1730 M. Street, NW, Suite 218
Washington, DC 20036

1-800-872-9855
https://osc.gov/

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV -2 2016

The Honorable Lynn Jenkins
U.S. House of Representatives
Washington, DC 20515

Dear Congresswoman Jenkins:

This is in final response to your November 2, 2015 letter requesting a review of the Consolidated Mail Outpatient Pharmacy (CMOP) program. We previously notified you that we were working on a national audit of the CMOP program. We have completed our work and enclosed is our report, *Audit of VHA's Consolidated Mail Outpatient Pharmacy Program.*

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

12/7/16

Dear Congressman Roe,

Congratulations on your selection as the Chairman of the Committee on Veterans' Affairs. Since being sworn in as the Inspector General of VA in early May, I have immersed myself in the work of our office. I have been impressed with the commitment and dedication of the staff, and we have been working hard to achieve of mission of effective oversight of the program and operations of VA.

As you prepare the agenda for the Committee, I would welcome the opportunity

to meet with you to discuss the topics of several upcoming OIG reports, or any other matters of interest. I look forward to working with you.

Sincerely,

Michael J. Missal

[redacted]

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 9 2016

The Honorable Niki Tsongas
Member, United States House
of Representatives
126 John Street, Suite 12
Lowell, MA 01852

Dear Congresswoman Tsongas:

This is in response to your December 9, 2016 letter requesting the VA Office of Inspector General (OIG) examine allegations of misconduct at the Edith Nourse Rogers Veterans Memorial Hospital in Bedford, Massachusetts, as well as a facility associated with the Hospital that houses veterans.

This matter is already under review by the appropriate OIG office. However, due to law enforcement and privacy concerns, additional information cannot be provided at this time. Please be aware that the same privacy and law enforcement concerns may prohibit us from releasing the results of our work in a report. However, we will make every effort to share whatever information we can accordance with applicable law.

Thank you for your interest in the Office of Inspector General.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 9 2016

(b)(6)

Dear (b)(6)

On the occasion of your retirement, please accept my sincere appreciation for a career dedicated to public service and America's veterans. The VA Office of Inspector General has been most fortunate that you chose to spend the last 34 years of your 37-year Federal career with us, making important contributions to the OIG's oversight of the Department of Veterans Affairs as an Investigative Assistant in the Office of Investigations, Los Angeles Western Field Office, in California. The OIG's success helping VA deliver on its promises to our veterans would not be possible without the dedication and talent of people like you.

You have my best wishes for a happy and fulfilling retirement. Godspeed!

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 14 2016

The Honorable Jeff Miller
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in response your November 23, 2016 request for an unredacted copy of any reports issued by the Office of Inspector General on (b)(6) Enclosed is a copy of the report, *Administrative Investigation - Alleged Conflict of Interest, Veterans Benefits Administration, Office of Economic Opportunity, Washington, DC* for the Committee's oversight purposes only. This report should not be released outside the Committee.

Thank you for your interest in the Office of Inspector General.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 15 2015

The Honorable Mark Kirk
Chairman
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
U.S. Senate
Washington, DC 20510

Dear Mr. Chairman:

The Senate Report to Accompany H.R. 2029, Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2016 directed the Office of Inspector General to review VA efforts to implement Antimicrobial Stewardship Programs at VA facilities. Enclosed is the result of that review, *Healthcare Inspection – Review of Antimicrobial Stewardship Programs in Veterans Health Administration Facilities*.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 15 2016

The Honorable Charlie Dent
Chairman
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Senate Report to Accompany H.R. 2029, Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2016 directed the Office of Inspector General to review VA efforts to implement Antimicrobial Stewardship Programs at VA facilities. Enclosed is the result of that review, *Healthcare Inspection – Review of Antimicrobial Stewardship Programs in Veterans Health Administration Facilities*.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 15 2016

The Honorable Jon Tester
Ranking Member
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
U.S. Senate
Washington, DC 20510

Dear Senator Tester:

The Senate Report to Accompany H.R. 202, Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2016 directed the Office of Inspector General to review VA efforts to implement Antimicrobial Stewardship Programs at VA facilities. Enclosed is the result of that review, *Healthcare Inspection – Review of Antimicrobial Stewardship Programs in Veterans Health Administration Facilities*.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 15 2015

The Honorable Sanford D. Bishop, Jr.
Ranking Member
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Bishop:

The Senate Report to Accompany H.R. 2029, Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2016 directed the Office of Inspector General to review VA efforts to implement Antimicrobial Stewardship Programs at VA facilities. Enclosed is the result of that review, *Healthcare Inspection – Review of Antimicrobial Stewardship Programs in Veterans Health Administration Facilities*.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 15 2016

The Honorable Nita Lowey
Ranking Member
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Congresswoman Lowey:

The Senate Report to Accompany H.R. 2029, Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2016 directed the Office of Inspector General to review VA efforts to implement Antimicrobial Stewardship Programs at VA facilities. Enclosed is the result of that review, *Healthcare Inspection – Review of Antimicrobial Stewardship Programs in Veterans Health Administration Facilities*.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 15 2016

The Honorable Barbara Mikulski
Ranking Member
Committee on Appropriations
U.S. Senate
Washington, DC 20510

Dear Senator Mikulski:

The Senate Report to Accompany H.R. 2029, Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2016 directed the Office of Inspector General to review VA efforts to implement Antimicrobial Stewardship Programs at VA facilities. Enclosed is the result of that review, *Healthcare Inspection – Review of Antimicrobial Stewardship Programs in Veterans Health Administration Facilities.*

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 15 2015

The Honorable Thad Cochran
Chairman
Committee on Appropriations
U.S. Senate
Washington, DC 20510

Dear Mr. Chairman:

The Senate Report to Accompany H.R. 2029, Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2016 directed the Office of Inspector General to review VA efforts to implement Antimicrobial Stewardship Programs at VA facilities. Enclosed is the result of that review, *Healthcare Inspection – Review of Antimicrobial Stewardship Programs in Veterans Health Administration Facilities*.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 15 2016

The Honorable Hal Rogers
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Senate Report to Accompany H.R. 2029, Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2016 directed the Office of Inspector General to review VA efforts to implement Antimicrobial Stewardship Programs at VA facilities. Enclosed is the result of that review, *Healthcare Inspection – Review of Antimicrobial Stewardship Programs in Veterans Health Administration Facilities*.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 15 2016

The Honorable Dianne Feinstein
U.S. Senate
Washington, DC 20510

Dear Senator Feinstein:

The Senate Report to Accompany H.R. 2029, Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2016 directed the Office of Inspector General to review VA efforts to implement Antimicrobial Stewardship Programs at VA facilities. Enclosed is the result of that review, *Healthcare Inspection – Review of Antimicrobial Stewardship Programs in Veterans Health Administration Facilities*.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Inspector General
Washington DC 20420

DEC 16 2016

The Honorable Shaun L. S. Donovan
Director, Office of Management and Budget
Executive Office of the President
Washington, DC 20503

Dear Mr. Donovan:

Please see the attached VA Office of Inspector General (OIG) report required under the *Government Charge Card Abuse Prevention Act of 2012* (Public Law 112-194). Pursuant to the Act, our report summarizes VA's progress towards implementing OIG recommendations related to VA's purchase card program.

OIG recognizes the potential for waste, fraud, and abuse of public funds within VA's purchase card program, and we perform regular oversight of this area. OIG conducted a risk assessment that will be published in the near future. Based on our internal risk assessment results, program financial reviews and audits were added to our FY 2017 Operational Plan.

If you need additional information, please contact our Assistant Inspector General for Management and Administration, (b)(6)

Sincerely,

Michael J. Missal
Inspector General

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 16 2016

The Honorable Joni K. Ernst
United States Senator
Washington, DC 20510

Dear Senator Ernst:

This is in response to your November 10, 2016 letter requesting additional information about the VA Office of Inspector General's (OIG) Hotline. Specifically, your letter requested additional information related to responses the OIG provided to Questions for the Record following the May 31, 2016 Committee on Homeland Security and Governmental Affairs field hearing in Tomah, Wisconsin. We appreciate the opportunity to provide further information about the OIG Hotline.

You first asked about any enhancements we have made to our Hotline. It should be noted at the outset that since the Hotline may serve as the initial point of contact for veterans, their families, VA employees, whistleblowers, and the general public, we recognize the need for it to be highly effective and accommodating. We have spent considerable time reviewing the policies and operations of our Hotline. Among the more significant enhancements are the following:

- We have hired additional staff, not only for the Hotline Division but also for the offices that will ultimately perform the reviews for accepted cases.

- We have personalized more of our responses so that we can be even more transparent to those who have contacted the Hotline.

- We are in the process of updating our internal policy that governs the OIG Hotline in areas where we feel we can be more responsive to complainants, particularly those where the OIG did not accept the complaint for further review.

- We are in the process of evaluating ways to strengthen the OIG Hotline Complaint Referral response process governed by VA Directive 0701, to include a mandate that the responsible official at the designated level sign all responses back to the OIG, and we plan to engage VA on this initiative to receive their support and cooperation on this effort.

We are continually reviewing our Hotline and will make further enhancements as we identify additional areas for improvement.

You next asked about the breakdown of fiscal year (FY) 2015 contacts to the Hotline and why they are 1,837 short of the total of 38,098. First, the 1,837 includes the 225 cases we opened as a result of a Hotline contact. As we noted in our original response, the OIG counts the number of individual contacts made to the Hotline. Since these represented our most significant contacts, it is likely that there were multiple contacts for each of the 225 cases. Because we do not normally track the number of contacts associated with each case, we are not able to determine the exact number of contacts associated with the 225 cases opened in FY 2015. Moreover, some of the numbers for the other categories involve rounding. We are confident that we examined each of the 38,098 contacts to our Hotline in FY 2015.

You further asked whether we keep demographic data on who contacts our Hotline. The OIG records whether the complainant self identifies, either overtly or implicitly, that they are a veteran or VA employee. In FY 2015, over 5,000 contacts originated from VA employees, and over 20,500 contacts came from veterans.

You also asked about the Freedom of Information Act (FOIA) process for contacts through our Hotline. When the OIG opens a case or external referral in response to a complaint, we provide two notifications to the complainant—once when we initiate action and again when we close the matter. When we inform the complainant we have closed the matter, we provide instructions for obtaining the results. The OIG has a dedicated office for processing FOIA and Privacy Act (PA) requests for OIG records that operates independently from VA's process for obtaining VA records. Adhering to FOIA/PA processes and principles ensures that we release information about specific veterans only to those who can demonstrate a legal right to obtain the information. We average approximately 19 days to respond to such requests.

With respect to your question on seeking consent to release an individual's identity, Section 7(b) of the *Inspector General Act of 1978*, as amended, states, "The Inspector General shall not, after receipt of a complaint or information from an employee, disclose the identity of the employee without the consent of the employee, unless the Inspector General determines such disclosure is unavoidable during the course of the investigation." Although the IG Act is silent on disclosing non-employee identities, we apply this requirement to all complainants with respect to external referrals to VA. The exception provided by Section 7(b) is infrequently used, but it can be particularly useful in emergent, potentially life threatening situations. For example, there have been instances in the past where a veteran with suicidal ideations will contact the OIG Hotline. In this situation, the Hotline analyst will disclose the veteran's identity to the Veterans' Crisis Line so that trained professionals can contact the veteran immediately. As a matter of policy, we seek an explicit Release of Identity for all complaints whether it is an open OIG project or an external referral.

You asked how many external case referrals to VA resulted in VA substantiating allegations. Of the 1,080 external referrals that were closed in FY 2015, the substantiation rate was approximately 39 percent. VA took 622 administrative sanctions and corrective actions in response to those findings.

Finally, you asked if additional resources and/or a reduced workload would result in the OIG accepting some of the cases we refer to VA. We are grateful to the Congress for increasing our appropriations for FY 2017. This positions us better to achieve our mission of effective oversight of the programs and operations of VA. Some of the increased appropriations are going to be used to accept more cases that come in through our Hotline. If we receive increased funding for FY 2018, I would anticipate even greater acceptance of cases.

I look forward to our meeting on Wednesday, January 4 and to further discussions on the operations and work of the OIG. Again, thank you for taking an interest in our organization and for providing the opportunity to more thoroughly explain our Hotline processes and operations. I wish you, your family, and staff a joyful holiday season.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 19 2016

The Honorable Ron Johnson
Chairman
Committee on Homeland Security
and Governmental Affairs
United States Senate
Washington, DC 20510

Dear Chairman Johnson:

This is in response to your February 27, 2015 letter cosigned with Chairman Charles Grassley of the Senate Committee on the Judiciary requesting that the Office of Inspector General (OIG) provide certain information concerning our oversight work on a semiannual basis. Our response is enclosed for the 6-month reporting period ending on September 30, 2016. We have provided a similar response to Chairman Grassley, Senator Thomas R. Carper, Ranking Member, Senate Committee on Homeland Security and Governmental Affairs, and Senator Patrick J. Leahy, Ranking Member, Senate Committee on the Judiciary under separate cover.

Thank you for your interest in the OIG.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 19 2016

The Honorable Charles E. Grassley
Chairman
Committee on the Judiciary
United States Senate
Washington, DC 20510

Dear Chairman Grassley:

This is in response to your February 27, 2015 letter cosigned with Chairman Ron Johnson of the Senate Committee on Homeland Security and Governmental Affairs requesting that the Office of Inspector General (OIG) provide certain information concerning our oversight work on a semiannual basis. Our response is enclosed for the 6-month reporting period ending on September 30, 2016. We have provided a similar response to Chairman Johnson, Senator Thomas R. Carper, Ranking Member, Senate Committee on Homeland Security and Governmental Affairs, and Senator Patrick J. Leahy, Ranking Member, Senate Committee on the Judiciary under separate cover.

Thank you for your interest in the OIG

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 19 2016

The Honorable Thomas R. Carper
Ranking Member
Committee on Homeland Security
and Governmental Affairs
United States Senate
Washington, DC 20510

Dear Senator Carper:

This is in response to a February 27, 2015 letter cosigned by Chairman Ron Johnson of the Senate Committee on Homeland Security and Governmental Affairs and Chairman Charles Grassley of the Senate Committee on the Judiciary requesting that the Office of Inspector General (OIG) provide certain information concerning our oversight work on a semiannual basis. Our response is enclosed for the 6-month reporting period ending on September 30, 2016. We have provided a similar response to Chairman Johnson, Chairman Grassley, and Senator Patrick J. Leahy, Ranking Member, Senate Committee on the Judiciary under separate cover.

Thank you for your interest in the OIG.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 19 2016

The Honorable Patrick J. Leahy
Ranking Member
Committee on the Judiciary
United States Senate
Washington, DC 20510

Dear Senator Leahy:

This is in response to a February 27, 2015 letter cosigned by Chairman Ron Johnson of the Senate Committee on Homeland Security and Governmental Affairs and Chairman Charles Grassley of the Senate Committee on the Judiciary requesting that the Office of Inspector General (OIG) provide certain information concerning our oversight work on a semiannual basis. Our response is enclosed for the 6-month reporting period ending on September 30, 2016. We have provided a similar response to Chairman Johnson, Chairman Grassley, and Senator Thomas R. Carper, Ranking Member, Senate Committee on Homeland Security and Governmental Affairs under separate cover.

Thank you for your interest in the OIG.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 27 2016

The Honorable Michael E. Horowitz
Inspector General
U.S. Department of Justice
950 Pennsylvania Avenue, N.W.
Suite 4706
Washington, D.C. 20530-0001

Dear Mr. Horowitz:

Thank you for providing the official draft Letter of Comment on December 21, 2016, for the Department of Veterans Affairs, Office of Inspector General Audit organization, conducted in accordance with the *Government Audit Standards* and the Council of the Inspectors General on Integrity and Efficiency guidelines.

We are pleased with the rating of pass and the opinion that our system of quality control has been suitably designed and complied with to provide assurance of performing and reporting, in conformity with applicable professional standards in all material aspects. Based on your assessment, you identified four findings in the Letter of Comment. We agree with the findings and recommendations presented in the draft report. The enclosure includes our comments addressing the recommendations. Corrective action either has been taken or will be taken to address each recommendation.

We wish to express our appreciation for the professionalism and thoroughness your team demonstrated while conducting the review. Based upon the feedback I received from my staff, they found the sharing of information and best practices with our team during the review most helpful. If you have any questions, please call (b)(6) Assistant Inspector General for Audits and Evaluations at (b)(6)

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 27 2016

The Honorable Michael E. Horowitz
Inspector General
U.S. Department of Justice
950 Pennsylvania Avenue, N.W.
Suite 4706
Washington, D.C. 20530-0001

Dear Mr. Horowitz:

Thank you for the opportunity to comment on the draft System Review Report dated December 21, 2016 that presents the results of your office's External Peer Review of the Department of Veterans Affairs, Office of Inspector General, Office of Audits and Evaluations. We are pleased that your office issued a pass rating on our system of quality control and concluded that for the period October 1, 2014 through September 30, 2015, the quality control function was appropriately designed and in compliance with the quality standards established by the Council of Inspectors General on Integrity and Efficiency.

We wish to express our appreciation for the professionalism and thoroughness your team demonstrated while conducting the review. Based upon the feedback I received from my staff, they found the sharing of information and best practices with our team during the review most helpful. If you have any questions, please call (b)(6) Assistant Inspector General for Audits and Evaluations at (b)(6)

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 27 2016

(b)(6)

Dear (b)(6)

On the occasion of your retirement, please accept my sincere appreciation for a career dedicated to public service and America's veterans. The VA Office of Inspector General has been most fortunate that you chose to spend the last 10 years of your 33-year Federal career with us, making important contributions to the OIG's oversight of the Department of Veterans Affairs as the Director in the Office of Healthcare Inspections in San Diego, California. The OIG's success helping VA deliver on its promises to our veterans would not be possible without the dedication and talent of people like you.

You have my best wishes for a happy and fulfilling retirement. Godspeed!

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 27 2016

(b)(6)

Dear (b)(6)

On the occasion of your retirement, please accept my sincere appreciation for a career dedicated to public service and America's veterans. The VA Office of Inspector General has been most fortunate that you chose to spend the last 14 years of your 34-year Federal career with us, making important contributions to the OIG's oversight of the Department of Veterans Affairs as a Director in the Manchester Healthcare Inspections Office in New Hampshire. The OIG's success helping VA deliver on its promises to our veterans would not be possible without the dedication and talent of people like you.

You have my best wishes for a happy and fulfilling retirement. Godspeed!

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 12 2016

The Honorable Emmanuel Cleaver, II
Member, United States House
of Representatives
211 Maple Avenue
Independence, Missouri 64050

Dear Congressman Cleaver:

This is in final response to a request from your staff, which we received on March 28, 2016 on behalf of (b)(6) alleged she did not receive appropriate care from the Kansas City VA Medical Center (VAMC) in Kansas City, Missouri. We informed you in a previous letter dated May 27, 2016 that the Office of Inspector General referred the allegations pertaining to her wound care to the Director of the VA Heartland Network (VISN 15), who has managerial oversight of the Kansas City VAMC, for review and response.

We have received and reviewed the VISN 15 Director's response, and we have closed our inquiry. Enclosed is a redacted copy of the VISN 15 Director's response. We made minimal redactions in accordance with exemption (b)(6) of the Freedom of Information Act, which authorizes the withholding of information that, if disclosed, would invade another individual's personal privacy.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

Department of Veterans Affairs

Memorandum

VA Heartland Network (VISN 15)

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

Date: July 27, 2016

From: Director, VA Heartland Network (10N15)

Subj: Response to VA OIG Congressional Referral #2016-03589-CR-0106

To: Director, VA OIG Hotline (53E)

1. The VA Heartland Network (VISN 15) response to the allegation of Inappropriate Use of Travel Card is as follows:

   Veteran Name: (b)(3):38 U.S.C. 5701

   Allegations:

   - (b)(3):38 U.S.C. 5701

2. The allegations of inappropriate care are unsubstantiated.

3. (b)(3):38 U.S.C. 5701

4.

5.

6.

7.

8.

9.

10. [redacted] reviewed the case.

11. Please contact [redacted] at [redacted]@va.gov, if any further information is needed related to this action.

WILLIAM P. PATTERSON, MD, MSS
Network Director
VA Heartland Network (VISN 15)

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 30 2015

The Honorable Jeff Flake
United States Senator
2200 East Camelback Road
Suite 120
Phoenix, Arizona 85016

Dear Senator Flake:

This is in final response to a request from your staff that we received on August 25, 2014, on behalf of (b)(6) concerning an alleged delay in care for his late brother, (b)(3):38 U.S.C. 5701 at the Phoenix VA Health Care System in Phoenix, Arizona. As we previously informed you in a letter dated January 16, 2015, we initiated a review of the allegations. Enclosed is the result of our review, *Healthcare Inspection – Delay in Care of a Lung Cancer Patient, Phoenix VA Health Care System, Phoenix, Arizona*.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 0 8 2016

The Honorable Sean Patrick Maloney
Member, United States House
of Representatives
123 Grand Street, Second Floor
Newburgh, New York 12550

Dear Congressman Maloney:

This is in response to your office's October 25, 2016 request on behalf of (b)(6) (b)(6) that the Office of Inspector General (OIG) reconsider (b)(6) request for an investigation into allegations of medical records tampering by clinicians at the James J. Peters VA Medical Center (VAMC) in Bronx, New York.

(b)(6) previously contacted the OIG Hotline regarding this matter on June 7, 2016. In response, we determined, based on the information and accompanying documentation submitted by (b)(6) that his complaint was administrative in nature and that he was already in the process of addressing his concerns through the appropriate channels at the Bronx VAMC. As such, we did not take additional action relating to this matter.

Your office submitted an inquiry to the OIG on (b)(6) behalf on July 12, 2016. Upon receipt of your office's request, both our investigations staff and our clinical staff conducted additional reviews of (b)(6) allegations, and they saw no grounds to warrant an OIG investigation or health care review. We informed your staff that our clinical staff reviewed (b)(6) medical record and concluded he has received and is continuing to receive reasonable care pertaining to his concerns. Further, we advised your staff that the OIG does not review allegations of poor care after a tort claim has been filed because doing so would be duplicative of and could impede the investigation that the VA Regional Counsel's office is required to conduct when a tort claim is filed. The Federal Tort Claims Act provides a means to resolve all issues regarding a tort claim.

Most recently, on October 25, 2016, your office requested that we reconsider our decision not to open an investigation into (b)(6) allegation of medical record tampering by Bronx VAMC clinicians. Our investigations staff conducted another review of (b)(6) allegations and supporting documents. However, they again saw no evidence of a criminal violation as alleged by (b)(6) In the absence of new information to support his allegations, we do not plan to initiate an investigation into this matter.

This appears to be a dispute between a patient and a provider concerning the accuracy of information recorded in the medical record. It is imperative that clinical providers document all care provided to a patient in the medical record, including information about what the clinician observes, perceives, and does in response to the information the patient shares with the clinician. A patient has the right to request that his medical record be amended if he believes that it contains information that is not accurate, relevant, timely, or complete. We note that (b)(6) exercised this right, and the Bronx VAMC granted his request several months ago in addition to reassigning him to a new primary care provider. If (b)(6) has similar concerns about other documentation or notes in his medical record, we encourage him to request additional amendments through the established process at the Bronx VAMC.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 22 2016

The Honorable Mazie K. Hirono
United States Senate
Washington, DC 20510

Dear Senator Hirono:

This is in final response to your August 6, 2015 request that the Office of Inspector General review select aspects of the VA Pacific Islands Health Care System (VAPIHCS), including access to care, travel benefits, cultural sensitivity, outreach and care for homeless veteran patients, and mental health care. Your letter also requested that we review the Veterans Health Administration's 6-point plan to address capacity and access to care within VAPIHCS primary care clinics. Enclosed is the result of our review, *Healthcare Inspection – Summarization of Select Aspects of the VA Pacific Islands Health Care System, Honolulu, Hawaii.*

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 16 2016

The Honorable Joni K. Ernst
United States Senator
Washington, DC 20510

Dear Senator Ernst:

This is in response to your November 10, 2016 letter requesting additional information about the VA Office of Inspector General's (OIG) Hotline. Specifically, your letter requested additional information related to responses the OIG provided to Questions for the Record following the May 31, 2016 Committee on Homeland Security and Governmental Affairs field hearing in Tomah, Wisconsin. We appreciate the opportunity to provide further information about the OIG Hotline.

You first asked about any enhancements we have made to our Hotline. It should be noted at the outset that since the Hotline may serve as the initial point of contact for veterans, their families, VA employees, whistleblowers, and the general public, we recognize the need for it to be highly effective and accommodating. We have spent considerable time reviewing the policies and operations of our Hotline. Among the more significant enhancements are the following:

- We have hired additional staff, not only for the Hotline Division but also for the offices that will ultimately perform the reviews for accepted cases.

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- We are in the process of evaluating ways to strengthen the OIG Hotline Complaint Referral response process governed by VA Directive 0701, to include a mandate that the responsible official at the designated level sign all responses back to the OIG, and we plan to engage VA on this initiative to receive their support and cooperation on this effort.

We are continually reviewing our Hotline and will make further enhancements as we identify additional areas for improvement.

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You also asked about the Freedom of Information Act (FOIA) process for contacts through our Hotline. When the OIG opens a case or external referral in response to a complaint, we provide two notifications to the complainant—once when we initiate action and again when we close the matter. When we inform the complainant we have closed the matter, we provide instructions for obtaining the results. The OIG has a dedicated office for processing FOIA and Privacy Act (PA) requests for OIG records that operates independently from VA's process for obtaining VA records. Adhering to FOIA/PA processes and principles ensures that we release information about specific veterans only to those who can demonstrate a legal right to obtain the information. We average approximately 19 days to respond to such requests.

With respect to your question on seeking consent to release an individual's identity, Section 7(b) of the *Inspector General Act of 1978*, as amended, states, "The Inspector General shall not, after receipt of a complaint or information from an employee, disclose the identity of the employee without the consent of the employee, unless the Inspector General determines such disclosure is unavoidable during the course of the investigation." Although the IG Act is silent on disclosing non-employee identities, we apply this requirement to all complainants with respect to external referrals to VA. The exception provided by Section 7(b) is infrequently used, but it can be particularly useful in emergent, potentially life threatening situations. For example, there have been instances in the past where a veteran with suicidal ideations will contact the OIG Hotline. In this situation, the Hotline analyst will disclose the veteran's identity to the Veterans' Crisis Line so that trained professionals can contact the veteran immediately. As a matter of policy, we seek an explicit Release of Identity for all complaints whether it is an open OIG project or an external referral.

You asked how many external case referrals to VA resulted in VA substantiating allegations. Of the 1,080 external referrals that were closed in FY 2015, the substantiation rate was approximately 39 percent. VA took 622 administrative sanctions and corrective actions in response to those findings.

Finally, you asked if additional resources and/or a reduced workload would result in the OIG accepting some of the cases we refer to VA. We are grateful to the Congress for increasing our appropriations for FY 2017. This positions us better to achieve our mission of effective oversight of the programs and operations of VA. Some of the increased appropriations are going to be used to accept more cases that come in through our Hotline. If we receive increased funding for FY 2018, I would anticipate even greater acceptance of cases.

I look forward to our meeting on Wednesday, January 4 and to further discussions on the operations and work of the OIG. Again, thank you for taking an interest in our organization and for providing the opportunity to more thoroughly explain our Hotline processes and operations. I wish you, your family, and staff a joyful holiday season.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV -7 2016

The Honorable Jeff Flake
United States Senator
2200 East Camelback Road
Suite 120
Phoenix, Arizona 85016

Dear Senator Flake:

This is in final response to your September 11, 2015 letter on behalf of a VA employee who raised a variety of allegations concerning a pharmacist at the Phoenix VA Health Care System (PVAHCS) in Phoenix, Arizona, who was also the subject of a January 2015 VA Administrative Investigative Board (AIB).

We previously informed you in a letter dated March 1, 2016 that we had reviewed the 234-page AIB and supporting documentation, the AIB's recommendations for corrective action, and the actions taken by PVAHCS in response to the AIB's recommendations. While our review determined that available documentation generally did not support the allegation that no meaningful actions were taken as a result of the AIB, we did identify a few matters where we felt it was necessary to obtain clarifying information from VA. As a result, we initiated an external referral to the Director of the VA Southwest Health Care Network, who has managerial oversight of the PVAHCS on this matter.

We have received and reviewed the Director's response, and we have closed our inquiry. Enclosed is a redacted version of the Director's response. We made redactions in accordance with exemption (b)(6) of the Freedom of Information Act, which authorizes the withholding of information that, if disclosed, would invade another individual's personal privacy.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosure

VHA RESPONSE TO OIG HOTLINE
Phoenix VA Health Care System
Allegations that Administrative Investigation Board (AIB) Recommendations Have Not Been Implemented
March 25, 2016

OIG Control Number: 2015-05515-CR-0154

ALLEGATION: The OIG has been contacted by Senator Jeff Flake regarding allegations that recommendations made in a 2015 Administrative Board of Investigation (AIB) regarding matters at the Phoenix VA Health Care System (PVAHCS) in Phoenix, Arizona, have not been implemented and that one of the AIB subjects, [redacted], remains in a full-time work-from-home arrangement more than a year after the AIB concluded but is not performing any work.

METHODOLOGY: The allegations were reviewed by [redacted], the Acting Chief of Staff, and [redacted], the Acting Associate Director. This review was completed by an official separate from and at a higher level than the staff in question.

BACKGROUND: On September 30, 2014, [redacted] Acting Medical Center Director, PVAHCS, issued a charge letter for [redacted], and [redacted] to conduct an AIB to investigate allegations that [redacted] or other members of the [redacted] engaged in Merit Systems Protection violations to include discrimination on the basis of gender, committed Prohibited Personnel Practices, violated OPM regulations or created a hostile work environment. On January 13, 2015, the Board submitted its final report to the new Acting Medical Center Director, [redacted]. The Board made eight (8) conclusions and made five (5) recommendations. On February 3, 2015, [redacted] indicated that he reviewed the final report and certified that the Board met the charge of the investigation.

SUMMARY AND FINDINGS:
Allegation 1: The AIB concluded in [redacted] 2015. Two of the three subjects resigned, and the third, [redacted], is drawing his salary and not doing any work at home. This allegation is unsubstantiated. [redacted] remains employed; however, was demoted and reassigned to a GS-13 position effective [redacted], 2015. [redacted] resigned from [redacted] VA position and cleared station effective [redacted], 2015. [redacted] resigned from [redacted] VA position and cleared station effective [redacted], 2015.

On [redacted], 2014 the Chief of Staff met with [redacted] to inform him he was to work from home. [redacted] received a memorandum (embedded) that he was to [redacted] and work on special assignments when requested. He was instructed to have no contact with other members of the [redacted] team during the AIB. [redacted] received similar memorandums.

Chg in Work Assignment -

Allegation 2: Requests were made for [redacted] to help out with the [redacted] workload and he refused. This allegation is unsubstantiated. [redacted] never refused to assist with [redacted] workload. In [redacted] 2015, [redacted] did feel that tasks he was asked to complete were inconsistent with his VA leadership functional statement and proposed other tasks that he felt were in alignment with his administrative expertise. See attached email.

[redacted] Duty Assignment [redacted]

Allegation 3: [redacted] has been without a [redacted] for almost 1 year with multiple acting [redacted] This allegation is substantiated. The [redacted] has had an Acting [redacted] since [redacted] 2014, and will continue to have one until the new [redacted], starts work on [redacted] 2016. Acting [redacted] are delegated the authority and responsibility of the [redacted] and are expected to perform the same functions as the [redacted]

Allegation 4: Staff were told [redacted] is not coming back and until he is removed, dismissed, retires, or quits, [redacted] cannot recruit another [redacted]. This allegation is unsubstantiated. Staff were never told that [redacted] was not coming back. A consistent message was delivered from the Chief of Staff, Deputy Chief of Staff, and acting [redacted] that specific information could not be shared as there was an ongoing investigation. It was communicated that whether there would be action against [redacted] was unknown until the investigation was concluded. This message was delivered to staff during regular [redacted] All Staff Meetings.

PVAHCS could not recruit for another [redacted] while [redacted] was still the [redacted]. It would have been inappropriate to take disciplinary action prior to the Board delivering its conclusions and recommendations to the Medical Center Director. [redacted] was removed from the [redacted] position, allowing PVAHCS to recruit, interview, and select a new [redacted].

ADDITIONAL QUESTIONS: In addition to the above allegations, the OIG requested the PVAHCS answer the following questions.

1. *If* [it] is accurate [that the only open recommendation is part of recommendation number 1 regarding the appropriate discipline for [redacted], what is the current status of AIB recommendation #1 pertaining to administrative action against [redacted] for all matters described in the AIB? Provide any available supporting documentation related to this matter.

[redacted] was one of the subjects of an AIB that stemmed from OIG Report 14-02603-267. Based on the recommendations of this investigation, on March 15, 2016, the Department of Veterans Affairs published a news release proposing the removal of three leaders at the Phoenix VA Health Care System, of which [redacted] was one. In accordance with due process, [redacted] has 60 days to appeal this decision.

2. Please explain the circumstances surrounding [redacted] departure from VA employment and indicate what steps were taken, if any, to recoup the funds improperly paid to him. If no steps were taken to attempt to recoup the funds, explain why not and who is responsible for the decision not to follow Federal statute. Provide any available supporting documentation related to this matter.

[redacted] chose to leave VA employment on his own accord. His resignation was tendered on [redacted], 2014. His resignation letter is embedded.

[redacted] Resignation Letter.pdf

5 U.S.C. 3110(b) prohibits [redacted] from advocating for the employment of [redacted]. Thus, the AIB's recommendation that the facility consider disciplinary action against [redacted] for advocating for [redacted]'s employment at PVAHCS was appropriate. However, 5 U.S.C. 3110(c) does not permit or require PVAHCS to recoup [redacted]'s salary solely because [redacted] advocated for his employment. Indeed, 5 U.S.C. 3110(c) explicitly leaves out the word "advocate". Rather, 5 U.S.C. 3110(c) states that recoupment of salary is only authorized where the individual was "appointed, employed, promoted, or advanced" due to a violation of the statute. In other words, to recoup [redacted]'s salary, VA would have to prove that either (a) [redacted] directly appointed [redacted] to the position of [redacted]; (b) [redacted] ordered another PVAHCS employee to appoint [redacted] to the position of [redacted]; or (c) PVAHCS appointed [redacted] to the position of [redacted] due to [redacted]'s advocacy and not because [redacted] was a qualified candidate for the position who received an appointment after following a lawful application process. Here, [redacted] applied for the position of [redacted], met the qualifications for that position, and received an appointment to that position only after he successfully interviewed for the position and PVAHCS verified his qualifications. Although there may have been cause to discipline [redacted] because he advocated for the employment of [redacted], that conduct is not sufficient grounds to recoup [redacted]'s salary under 5 U.S.C. 3110(c) because ample evidence shows that [redacted] received a lawful appointment to the position of [redacted] after he applied for the position and PVAHCS determined that he was qualified for the position.

3. Was [redacted] instructed to work from home while the AIB was underway? When did this arrangement go into effect? When did it end? If [redacted] has not returned to the office, why not? Provide any available supporting documentation related to this matter.

On [redacted], 2014, [redacted] received instructions to perform work at home during the conduct of the AIB. On [redacted], 2015, [redacted], contacted [redacted] by email to correspond about other duties [redacted] could perform via telework. [redacted] continues to telework to this date. [redacted] was demoted from his position as the [redacted] as a result of the AIB. An agreement was reached whereby [redacted] will continue to work remotely as a pharmacist.

[redacted] Clg in Work Assignment - [redacted].

[redacted] Brief Work Duty Suggestions [redacted].c

[redacted] Telework Agreement.pdf

4. [redacted] SF-50 dated [redacted] 2015, states that his position requires [redacted] and full-time [redacted]. Do the duties of his GS-13 [redacted] position allow for full-time work-from-home arrangements? Provide any available supporting documentation related to this matter to include any formal telework or virtual employee arrangements.

Yes, [redacted] duties allow him to work from home full time. The telework agreement is embedded in item 3 above.

5. Who supervises [redacted] directly, and what measures are in place to monitor his productivity while he is working from home full-time? During his time working from home, did [redacted] refuse any assignments that involve assisting with the [redacted] workload? How were any incidents fitting this description handled?

[redacted] reports directly to the [redacted], [redacted], currently supervises [redacted]. [redacted] reports regularly about his duties via email and records daily activities on a spreadsheet that is emailed to the [redacted] (spreadsheet embedded). [redacted] has been working effectively at home under his telework agreement. He has not refused any assignments and has performed well in both budgetary and routine pharmacist duties. No negative or adverse incidents have occurred regarding [redacted] teleworking arrangement, nor has he refused assignments.

[redacted] Work Documentation.xlsx

6. Who replaced [redacted] as Chief of Staff? Is this person(s) in an Acting capacity, and if so, why has a permanent Chief not been selected?

[redacted] was not the Chief of Staff, but the [redacted]. PVAHCS has had an Acting [redacted] from [redacted], 2014 to present. [redacted] is the current Acting [redacted]. [redacted] was selected as the permanent [redacted] with an effective start date of [redacted] 2016.

Contact for Further Information: [redacted], Program Manager, Quality, Safety, and Improvement Department, at [redacted] or [redacted].

Deborah Amdur

DEBORAH AMDUR, MSW
Medical Center Director

04/04/2016
Date

Edited 3/24/2016

Phoenix VA Health Care System
July 26, 2016

OIG Control Number: 2016-05515-CR-0154 (#2)

Amendment as requested on June 2, 2016, by Office of Inspector General Congressional Relations (50B).

Additional amendments requested and completed on September 23, 2016.

A. On the matters relating to [redacted]'s telework arrangement:

- Documentation Requested:
  - A copy of the agreement reached between [redacted] and PVAHCS allowing him to work remotely full-time as a [redacted].


Change in Work Assignmt 10_14_2014


[redacted] Telework Agreement 2015

[redacted]'s position and duties meet requirements in VA Handbook 5011/26, Part II, Chapter 4, "Alternative Workplace Arrangements (Telework)"

  - A copy of [redacted]'s GS-13 position description.


PD_0513_Pogliano

Please note: The document embedded above is a Functional Statement, not a Position Description. Title 5 employees have Position Descriptions whereas Hybrid Title 38 employees have Functional Statements. [redacted] is employed as a [redacted] in the Hybrid Title 38 Occupational Series [redacted]

  - A copy of any rating [redacted] received since his demotion.


[redacted]_Rating.pdf

  - Evidence supporting PVAHCS' decision to allow a [redacted] to work from home 100 percent of the time.

[redacted] received a two-grade demotion, but is still employed as a [redacted] not a [redacted]. Please see the Telework

Edited 3/24/2016

Agreement (embedded in the first bullet above and question 3 of the original response) allowing [redacted] to work full-time from a home office. All duties performed by [redacted] are able to be accomplished virtually.

- It is unclear why [redacted] is teleworking full-time and effectively performing Title 5 duties while continuing to receive Hybrid Title 38 pay.

[redacted] is teleworking full time because PVAHCS felt it would be better for the psychological safety of all involved since [redacted] employees may not have been comfortable interacting face to face with [redacted] whom they had given testimony about during the AIB that led to [redacted] demotion. [redacted] performs [redacted] duties that can be done 100% virtually via computer. Duties include, but are not limited to:

- [redacted]

Discuss the agreement reached between PVAHCS and [redacted] and explain why PVAHCS agreed to this arrangement. How did it come about? Was it the result of a grievance, etc.?

Initially, PVACHS proposed [redacted]'s removal from Federal service. [redacted] filed an Equal Employment Opportunity complaint alleging age discrimination. Discussions with [redacted]'s legal representation and VA representatives led to a mutual agreement of a voluntary demotion. PVAHCS determined that [redacted] is a good employee who was in a position not suited for him, so in the best interest of the agency PVAHCS leadership decided to demote [redacted] rather than remove him. The demotion had financial consequences for [redacted] as well as a negative impact on his professional stature.

- Are there any other employees with the same responsibilities as [redacted], and are they allowed to telework full-time? If not, why are there special privileges in place for [redacted]?

  Yes, other [redacted] at PVAHCS have approved telework agreements allowing them to telework from a home office 100% of the time if their duties are able to be conducted virtually. There are currently three [redacted] in addition to [redacted] teleworking from home offices with another three [redacted] being assessed for telework agreements. No special privileges are in place for [redacted].

- Was [redacted]'s position description modified to allow him to work his current duties full-time? If not, how long is he scheduled to perform his current duties?

  Yes, as part of the demotion, [redacted]'s Functional Statement was changed from a full-time GS-15 [redacted] to a full-time GS-13 [redacted]. New duties were assigned as described above. No additional changes in [redacted]'s duties are planned at this time.

B. On the matters relating to [redacted]:

Please provide additional information justifying the specific PVAHCS responses listed below and responding to OIG follow-up questions.

- PVAHCS Response: "5 USC 3110(c) does not permit or require PVAHCS to recoup [redacted]'s salary solely because [redacted], advocated for his employment."

OIG Response: 5 USC 3110(b) provides that a "public official [redacted]] may not appoint, employ, promote, or advocate for appointment, employment, promotion, or advancement...any individual [redacted]] who is a relative of the public official." In the event any of these prohibited actions takes place and the public official's relative benefits from the prohibited activity (i.e. the relative is hired), 5 USC 3110(c) goes on to state that any individual [redacted]] "appointed, employed, promoted, or advanced in

violation of this section is not entitled to pay, and money may not be paid from the Treasury as pay to an individual [redacted] so appointed, employed, promoted, or advanced."
In order to qualify as a public official under the anti-nepotism statute, the employee must have the authority to appoint, employ, promote, or advance individuals or to recommend individuals for such actions. If an employee with such authority advocated for the appointment, employment, advancement, promotion of a relative, the statute is also violated. Thus, the public official need not be the individual who officially approved the appointment; it is illegal if the public official advocated the appointment of their relative.

According to the AIB, [redacted] was the then [redacted] at PVAHCS at the time the matters investigated by this AIB took place. In this position, was [redacted] considered a public official with the authority to appoint, employ, promote, or advance individuals, or to recommend such actions in connection with employment in an agency? Why or why not?

> [redacted] *was a public official with the authority to appoint, employ, promote, or advance individuals, but had no hiring or administrative authority over the* [redacted] *at PVAHCS. As the* [redacted] *'s authority and jurisdiction was limited to the* [redacted]. *While there was no direct evidence that* [redacted] *ordered Human Resources or the* [redacted] *to hire* [redacted], *the AIB did conclude that he engage in nepotism. He had no authority to do so as the* [redacted] *is organizationally structured under a clinical chain of command whereas the* [redacted] *is aligned under an administrative branch of PVAHCS. If OIG believes violations of 5 USC 3110(b) or 5 USC 3110(c) occurred, the PVAHCS will take under advisement OIG's recommendations in this regard.*

- PVAHCS Response: "To recoup [redacted]'s salary, VA would have to prove that either (a) [redacted] directly appointed [redacted] to the position of [redacted]; (b) [redacted] ordered another PVAHCS employee to appoint [redacted] to the position of [redacted]; or (c) PVAHCS appointed [redacted] to the position of [redacted] due to [redacted] advocacy and not because [redacted] was a qualified candidate for the position who received an appointment after following a lawful application process.

OIG Response: The nepotism statute states that when a public official [redacted] engages in any of the activities listed in 5 USC 3110(b) and the relative [redacted] is appointed, employed, promoted, or advanced, then the relative [redacted] is not entitled to pay.

Furthermore, whether or not [redacted] was a qualified candidate for the position remains questionable considering [redacted] was found to have improperly altered [redacted]'s Knowledge, Skills, and Abilities (KSAs). As one AIB witness testified, "it

was real hard to pull information even getting him hired at a [GS-]5. [redacted] was appointed to a GS-5 [redacted] position after [redacted] improperly altered [redacted]'s KSAs, in the determination of the AIB, "to increase the complexity of [redacted]'s work history to meet the qualification standards for the GS-6 [redacted] position instead of the GS-5 qualification standards his KSAs were determined to match." (Page 160) However, despite this inappropriate activity, the [redacted] Review Board still determined [redacted] did not qualify for a GS-6 position. In order to hire [redacted], PVAHCS staff admitted to specially creating a new functional statement for a [redacted] at a lower grade level than what is considered the standard entry level for a [redacted] at PVAHCS. (Page 171)

Why did [redacted]'s conduct not meet the standard for nepotism? Is there a legal opinion from VA Regional Counsel addressing whether 1) [redacted] violated the nepotism statute, 2) whether [redacted] is entitled to pay using money from the Treasury if the nepotism statute was violated by [redacted], and 3) whether [redacted] was truly qualified for the position to which he applied and was appointed? If not, please request one and provide a copy of the results.

1) *PVAHCS does not dispute the AIB's conclusions that [redacted] engaged in nepotism or that [redacted] facilitated nepotism. [redacted] was removed from employment at the PVAHCS. [redacted] was demoted.*

2) *In its initial response to OIG, PVAHCS provided its reasoning for not recouping salary paid to [redacted]. PVAHCS has no additional information to provide in this regard. PVAHCS intends to take under advisement OIG's recommendations in this regard.*

3) *The Human Resources Department determined that [redacted] met the minimum qualifications as a [redacted]. VA Handbook 5005/15, Part II, [redacted] Qualification Standard [redacted]" sets grades for [redacted] at GS-2 through GS-8. Whether the Professional Standards Board would have recommended a lower grade in light of the finding that [redacted] improperly altered his Knowledge, Skills, and Abilities (KSAs) is unknown.*

4) *PVAHCS conferred with the Office of General Counsel (OGC) to prepare this response.*

Update – September 23, 2016: Regarding the nepotism issue, the PVAHCS consulted with [redacted], Attorney, Office of General Counsel, [redacted]

- PVAHCS Response: "[redacted] applied for the position of [redacted], met the qualifications for that position, and received an

appointment to that position only after he successfully interviewed for the position and PVAHCS verified his qualifications."

OIG Response: See response to previous question. The AIB shows that [redacted] applied for an entry-level GS-6 [redacted] position and that he did not meet the qualifications for the position. All entry-level [redacted] positions began at the GS-6 level prior to [redacted]'s application (Pages 164 and 168). His KSAs, which were found to have been improperly altered by [redacted], were then used as the basis for qualifying him for a GS-6 position. Prior to his appointment, there were no GS-5 [redacted] positions. According to AIB testimony, the position was created for the purpose of hiring [redacted]. [redacted] testified during his AIB interview that because of [redacted]'s insistence in the matter, he wound up hiring someone [redacted] with less credentials than he needed for the job that he needed done. (Page 169) Please provide evidence of a legal opinion supporting this position.

[redacted] was demoted for his actions associated with [redacted]'s appointment.

The Human Resources Department determined that [redacted] met the minimum qualifications as a [redacted] although it is unknown what grade the Professional Standards Board would have recommended if [redacted] had not altered [redacted]'s KSAs.

PVAHCS had no additional information to provide in this regard. PVAHCS intends to take under advisement OIG's recommendations in this regard.

PVAHCS conferred with the Office of General Counsel (OGC) to prepare this response.

- PVAHCS Response: "Although there may have been cause to discipline [redacted] because he advocated for the employment of [redacted], that conduct is not sufficient grounds to recoup [redacted]'s salary under 5 U.S.C. 5110(c) because ample evidence shows that [redacted] received a lawful appointment to the position of [redacted] after he applied for the position and PVAHCS determined that he was qualified for the position."

OIG Response: The issue here is not whether [redacted] was qualified for the position, but whether [redacted] advocated for the appointment or employment of [redacted] in violation of the [redacted] statute. Again, the statute is quite clear that in such instances [redacted] who benefitted from the advocacy is not entitled to pay using money from the Treasury. Furthermore, testimony from the AIB suggests that [redacted] was found not qualified for the position until [redacted] improperly modified his KSAs. Please provide evidence of a legal opinion supporting this position.

If after review of this response, OIG concludes that [redacted]'s actions violated the nepotism statute, PVAHCS will take under advisement that [redacted] received money from the Treasury as a result of nepotism. However, PVAHCS believes pursuing recuperation of funds from a former GS-5 employee who performed satisfactorily would result in a protracted legal battle.

[redacted] worked for PVAHCS from [redacted], 2014, to [redacted], 2014, as a GS-5 earning a fraction of the $32,348 per annum compensation. PVAHCS believes the monetary costs to the government would be greater than any recovered funds.

While PVAHCS concluded the best course of action was not to pursue recovery of funds paid to [redacted], as the oversight body for fraud, waste, and abuse, the PVAHCS fully understands that OIG has the option to pursue that course of action.

C. On the matters relating to recruiting another [redacted]

- Allegation 4 stated, "Staff were told [redacted] is not coming back and until he is removed, demoted, retires, or quits [redacted] cannot recruit another [redacted]." PVAHCS asserted that the allegation was unsubstantiated, yet the first sentence of the second paragraph in PVAHCS' response to Allegation 4 states, "PVAHCS could not recruit for another [redacted] while [redacted] was still the [redacted]." Justify how PVAHCS determined this allegation was fully unsubstantiated.

Prior to his demotion, PVAHCS could not recruit for a new [redacted] because the position was encumbered by [redacted]. Had [redacted] been absolved of any wrong doing, [redacted] could have been reinstated as the [redacted]. PVAHCS determined it appropriate to wait for the conclusion of the AIB and the recommendations of the Board before taking any disciplinary action. Taking disciplinary action before the conclusion of the AIB, such as removing an employee from a position, could result in allegations of wrongdoing by PVAHCS and legal action against the VHA.

[redacted]'s duties were reassigned on [redacted], 2014, at the recommendation of the AIB. His demotion occurred on [redacted] 2015. When his appeal period ended, PVAHCS recruited and hired a new permanent [redacted] who started on [redacted], 2016.

OIG Response (September 2016)
Provide clarification as to whether or not [redacted] staff was informed that [redacted], "is not coming back and until he is removed, demoted, retires, or quits [redacted] cannot recruit another [redacted]." While we do not disagree with PVAHCS's explanation, it does not answer the allegation

Update – September 23, 2016: PVAHCS staff were never told that [redacted] was not coming back and until he is removed, demoted, retires or quits [redacted] cannot recruit another [redacted] The Acting [redacted] has no recollection of ever making any statement to that effect to [redacted] staff. A consistent message was delivered from the Chief of Staff, Deputy Chief of Staff, and Acting [redacted] that specific information could not be shared as there was an ongoing investigation. It was communicated that whether there would be action against [redacted] was unknown until the investigation was concluded. This message was delivered to staff during regular Pharmacy All Staff Meetings.

Contact for Further Information: [redacted], Program Manager, Quality, Safety, and Improvement Department, at [redacted] or [redacted].

Updated September 23, 2016

BARBARA FALLEN, FACHE — Date
Acting Medical Center Director

Edited 3/24/2016

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 19 2016

The Honorable Thomas R. Carper
Ranking Member
Committee on Homeland Security
and Governmental Affairs
United States Senate
Washington, DC 20510

Dear Senator Carper:

This is in response to a February 27, 2015 letter cosigned by Chairman Ron Johnson of the Senate Committee on Homeland Security and Governmental Affairs and Chairman Charles Grassley of the Senate Committee on the Judiciary requesting that the Office of Inspector General (OIG) provide certain information concerning our oversight work on a semiannual basis. Our response is enclosed for the 6-month reporting period ending on September 30, 2016. We have provided a similar response to Chairman Johnson, Chairman Grassley, and Senator Patrick J. Leahy, Ranking Member, Senate Committee on the Judiciary under separate cover.

Thank you for your interest in the OIG.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 19 2016

The Honorable Charles E. Grassley
Chairman
Committee on the Judiciary
United States Senate
Washington, DC 20510

Dear Chairman Grassley:

This is in response to your February 27, 2015 letter cosigned with Chairman Ron Johnson of the Senate Committee on Homeland Security and Governmental Affairs requesting that the Office of Inspector General (OIG) provide certain information concerning our oversight work on a semiannual basis. Our response is enclosed for the 6-month reporting period ending on September 30, 2016. We have provided a similar response to Chairman Johnson, Senator Thomas R. Carper, Ranking Member, Senate Committee on Homeland Security and Governmental Affairs, and Senator Patrick J. Leahy, Ranking Member, Senate Committee on the Judiciary under separate cover.

Thank you for your interest in the OIG

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 19 2016

The Honorable Ron Johnson
Chairman
Committee on Homeland Security
and Governmental Affairs
United States Senate
Washington, DC 20510

Dear Chairman Johnson:

This is in response to your February 27, 2015 letter cosigned with Chairman Charles Grassley of the Senate Committee on the Judiciary requesting that the Office of Inspector General (OIG) provide certain information concerning our oversight work on a semiannual basis. Our response is enclosed for the 6-month reporting period ending on September 30, 2016. We have provided a similar response to Chairman Grassley, Senator Thomas R. Carper, Ranking Member, Senate Committee on Homeland Security and Governmental Affairs, and Senator Patrick J. Leahy, Ranking Member, Senate Committee on the Judiciary under separate cover.

Thank you for your interest in the OIG.

Sincerely,

MICHAEL J. MISSAL

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

DEC 19 2016

The Honorable Patrick J. Leahy
Ranking Member
Committee on the Judiciary
United States Senate
Washington, DC 20510

Dear Senator Leahy:

This is in response to a February 27, 2015 letter cosigned by Chairman Ron Johnson of the Senate Committee on Homeland Security and Governmental Affairs and Chairman Charles Grassley of the Senate Committee on the Judiciary requesting that the Office of Inspector General (OIG) provide certain information concerning our oversight work on a semiannual basis. Our response is enclosed for the 6-month reporting period ending on September 30, 2016. We have provided a similar response to Chairman Johnson, Chairman Grassley, and Senator Thomas R. Carper, Ranking Member, Senate Committee on Homeland Security and Governmental Affairs under separate cover.

Thank you for your interest in the OIG.

Sincerely,

MICHAEL J. MISSAL

Enclosure

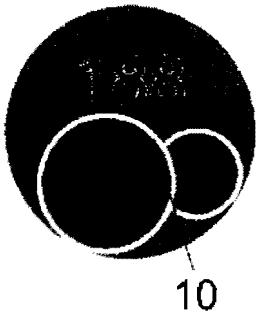
DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

RESPONSE TO JOINT REQUEST FROM THE U.S. SENATE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS AND THE U.S. SENATE COMMITTEE ON THE JUDICIARY FOR INFORMATION REGARDING OIG OVERSIGHT ACTIVITIES FOR THE REPORTING PERIOD APRIL 1–SEPTEMBER 30, 2016

DECEMBER 19, 2016

I. ACCOUNTING OF ALL OUTSTANDING UNIMPLEMENTED RECOMMENDATIONS AND AGGREGATE POTENTIAL COST SAVINGS

The Office of Inspector General (OIG) considers a recommendation to be "outstanding" when VA does not implement it within 1 year of its issuance. Our response to Question 1 will focus only on recommendations meeting this criterion unless otherwise noted. The Venn diagrams immediately below provide an overview of the total number of reports and recommendations open as of September 30, 2016. Appendix A lists each outstanding open recommendation in ascending chronological order.



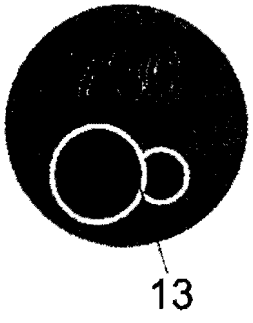
REPORTS

188 – Total Open Reports as of September 30, 2016

69 – Number of Open Reports Considered "Outstanding" (37%)

17 – Number of Open Reports with an Associated Monetary Benefit (9%)

10 – Number of Open Reports both Considered Outstanding and Having an Associated Monetary Benefit (5%)



RECOMMENDATIONS

736 – Total Open Recommendations as of September 30, 2016

88 – Number of Open Recommendations Considered "Outstanding" (26%)

33 – Number of Open Recommendations with an Associated Monetary Benefit (4%)

13 – Number of Open Recommendations both Considered Outstanding and Having an Associated Monetary Benefit (2%)

A. Number of Open and Unimplemented Recommendations

As of September 30, 2016, there were 188 open OIG reports with 736 unimplemented recommendations designed to promote economy, efficiency, and effectiveness in the administration of, and to prevent and detect fraud and abuse in, VA programs and operations. Of this total, 69 reports containing 188 recommendations are considered "outstanding" as of September 30, 2016 because VA has not implemented them within 1 year of our issue date.

B. Dates on Which the Open Recommendations Were Initially Made

Please refer to Appendix A for additional information. We issued our oldest unimplemented recommendation on June 7, 2010.

C. Agency Management Agreement or Disagreement with the Recommendations

Agency management agreed to all of the recommendations we issued during the reporting period except for those listed in Appendix B.

D. Total Potential Cost Savings of Open and Unimplemented Recommendations

The monetary benefit associated with all unimplemented OIG recommendations totals $4,152,989,912. This cumulative total is associated with 33 recommendations contained in 17 OIG reports.

Of the 69 outstanding reports and 188 outstanding recommendations listed in Appendix A, 10 reports containing 13 recommendations have an associated monetary benefit. The cumulative monetary benefit of these 13 outstanding recommendations totals $1,454,268,597.

When possible, we calculate a specific cost savings amount for a single recommendation. However, in some cases our recommendations are codependent and it is more appropriate to calculate a shared cost savings amount for a group of recommendations in the same report. In other words, VA will not realize the cost savings until it implements all recommendations associated with that particular amount. There are six reports listed in Appendix A containing recommendations with a shared cost savings amount. Each report is footnoted with additional information.

II. AGENCY RESPONSES NOT RECEIVED WITHIN 60 DAYS

None.

III. INSTANCES OF SUBSTANTIATED MISCONDUCT OF GS-15 OR ABOVE VA EMPLOYEES WHERE NO PROSECUTION RESULTED

Appendix C lists each public OIG work product issued during the reporting period that is responsive to this request. The Administrative Investigations Division within the OIG's Office of Investigations has primary responsibility for investigating allegations of misconduct concerning high-ranking senior officials and other high profile matters of interest to Congress and the Department. While these investigations generally are not criminal in nature, we will refer certain matters to the U.S. Department of Justice for a prosecutorial decision as appropriate.

Occasionally, we may also identify senior official misconduct through other forms of OIG work, including audits, reviews, and healthcare inspections. In our report, *Review of VHA's Alleged Manipulation of Appointment Cancellations at VAMC Houston, Texas* (June 20, 2016), we recommended the Veterans Integrated Service Network 16 Director confer with VA's Office of Accountability Review to determine what, if any, administrative action should be taken regarding instructions to staff to incorrectly record appointments as canceled by patient. In their response to our recommendation, they concurred with the recommendation provided the following information:

> *VISN 16 Response: Concur. We consulted with the VA Office of Accountability Review (OAR) which is responsible for advising on possible administrative actions toward Senior Executive Service (SES) employees and members of a hospital's leadership quadrad. The Director of the two CBOCs was not in a senior leadership position, and thus consideration of administrative actions does not fall within the purview of OAR. The CBOC Director was using their best judgement to accurately reflect the scheduling transaction, and did not engage in malicious or ethically unjustifiable conduct or deliberately manipulate scheduling data. Accordingly, no administrative actions are warranted against the CBOC Director.*

IV. INSTANCES OF WHISTLEBLOWER REPRISAL

We neither reviewed nor substantiated any allegations of whistleblower reprisal during this reporting period. Although the OIG is authorized to review allegations of whistleblower reprisal, we make a concerted effort to avoid reviewing matters that would duplicate the efforts or mission of other VA offices or Federal agencies. Generally, we do not review allegations of whistleblower reprisal and instead refer complainants to the U.S. Office of Special Counsel (OSC). OSC is a separate Federal agency with authority to review allegations of prohibited personnel practices, including reprisal for whistleblowing, and take action on behalf of the employee and against the supervisor who retaliated. The OIG does not have this authority.

V. AGENCY ATTEMPTS TO INTERFERE WITH IG INDEPENDENCE

None.

VI. INSTANCES OF AGENCY RESISTANCE TO OIG OVERSIGHT ACTIVITIVES

None.

VII. CLOSED OIG WORK NOT PUBLICLY DISCLOSED

The OIG conducts investigations, audits, reviews, evaluations, and inspections, and we go to considerable lengths to make the results of our work public through our website, www.va.gov/oig. Under some circumstances, we cannot post information about our work on the internet because Federal laws protect certain information from disclosure. However, to promote transparency we promptly release all completed work that is not otherwise prohibited from disclosure or does not involve prosecutorial sensitive information.

APPENDIX A

ACCOUNTING OF ALL OUTSTANDING UNIMPLEMENTED RECOMMENDATIONS FOR THE REPORTING PERIOD APRIL 1–SEPTEMBER 30, 2016

Our expectation for the vast majority of our reports is for VA to implement all recommendations within 1 year of issuance of our final report. Timely implementation of OIG recommendations enhances the impact of OIG work to the benefit of veterans, their families, and taxpayers. To achieve this outcome, the OIG operates a centralized follow-up process to track implementation of all OIG report recommendations. For a comprehensive explanation of our follow-up process, please refer to our June 9, 2010, testimony on this subject before the Committee on Veterans' Affairs, U.S. House of Representatives.[1] Though the testimony itself is somewhat dated, the follow-up process described therein remains in effect today.

As of September 30, 2016, there are 188 open OIG reports with 736 unimplemented recommendations. Of this total, 69 reports containing 188 recommendations are considered "outstanding." Ten outstanding reports containing 13 outstanding recommendations have an associated monetary benefit totaling $1,454,268,597. All outstanding reports and recommendations are listed in the table that follows.

[illegible] Report Number [illegible], Issued [illegible]	
Recommendation 1: We recommended that the Deputy Assistant Secretary for OAL [Office of Acquisitions and Logistics] direct the NAC [National Acquisition Center] to not award any 621 I contracts unless the Contracting Officer can determine that the prices offered are fair and reasonable.	--
Recommendation 2: We recommended that the Deputy Assistant Secretary for OAL direct the NAC to eliminate national NTE [not-to-exceed] pricing as a pricing objective, and to establish pricing objectives under 621 I contracts that are consistent with the goals of the FSS [Federal Supply Schedule] Program MFC [Most Favored Customer] pricing, or the best pricing to commercial customers purchasing under similar terms and conditions as the Government.	--
Recommendation 3: We recommended that the Deputy Assistant Secretary for OAL direct the NAC to revise the 621 I Solicitation's CSP [Commercial Sales Practices] format to require disclosure of information relevant to Recommendation 2.	--
Recommendation 4: We recommended that the Deputy Assistant Secretary for OAL direct the NAC to use price analysis methodologies that place significant reliance on the 621 I CSP disclosures, once revised.	--
Recommendation 5: We recommended that the Deputy Assistant Secretary for OAL direct the NAC to cease using comparisons to existing FSS prices and/or national market surveys as methodologies for establishing price reasonableness.	--

[1] See *Statement of Richard J. Griffin, Deputy Inspector General, Office of Inspector General, U.S. Department of Veterans Affairs Before the Committee on Veterans' Affairs, United States House of Representatives Hearing on "Office of Inspector General's Open Recommendations: Are We Fixing The Problems?"* (June 9, 2010). http://www.va.gov/oig/pubs/statements/VAOIG-statement-20100609-Griffin.pdf.

2. Audit of the Veterans Service Network **Report Number 09-03809-99, Issue Date: February 16, 2010**	
Recommendation 3: We recommended the Assistant Secretary, Office of Information and Technology, define the level of effort and apply the resources required to complete data migration for all entitlement programs and decommission the Benefits Delivery Network legacy system.	$35,000,000
3. Review of VA Solicitation Regarding Contracts with Affiliated Individuals **Report Number 09-00582-232, Issue Date: July 21, 2009**	
Recommendation 11: We recommended that the Under Secretary for Health seek a legislative amendment to 38 U.S.C. § 8153 and § 7409 to authorize VA to enter into personal services contracts when the services are to be provided at a VA facility.	--
4. Audit of VA's Prosthetic Supply Inventory Management **Report Number 10-00612-85, Issue Date: March 30, 2011**	
Recommendation 5: We recommended the Under Secretary for Health revise the VHA's Inventory Management Handbook to require at least one prosthetic supply inventory manager from each VA medical center to attend VA's Acquisition Academy's Supply Chain Management School and become Certified VA Supply Chain Managers.	$35,500,000[2]
5. Audit of VA Regional Office Appeals Management Processes **Report Number 10-03136-75, Issue Date: May 30, 2012**	
Recommendation 1: We recommended the Under Secretary for Benefits identify and request the staffing resources needed to meet Veterans Benefits Administration's processing goals and conduct de novo reviews on all appeals.	--
Recommendation 2: We recommended the Under Secretary for Benefits revise productivity standards for decision review officers assigned to appeal processing to limit credit to actions that progress the appeal such as Notices of Disagreement, issuance of Statements/Supplemental Statements of the Case, conducting requested hearings, and certification of appeals.	--
Recommendation 3: We recommended the Under Secretary for Benefits implement criteria requiring appeals staff to initiate a review or development for Notices of Disagreement and certified appeals within 60 days of receipt.	--
Recommendation 4: We recommended the Under Secretary for Benefits revise current policy to require de novo reviews on all appeals.	--
6. Review of the Enhanced-Use Lease between the Department of Veterans Affairs and Veterans Development, LLC **Report Number 12-00376-290, Issue Date: September 28, 2012**	
Recommendation 4: We recommended that the Executive in Charge for the Office of Management and Chief Financial Officer and VA's General Counsel convene an independent group to determine the appropriateness and the legal sufficiency of the Brecksville Enhanced Use Lease [EUL] and service agreements contained in the EUL, particularly in light of the indictment of Michael Forlani and the suspension of VetDev [Veterans Development, LLC] and other entities identified in the indictment, and take appropriate action to include long and short term plans, including the renegotiation of the terms and conditions of the agreements for the administration building and the parking garage.	--

[2] This Better Use of Funds amount was a shared value for Recommendations 1–10 in our report. Only Recommendation 5 remains open at this time.

Recommendation 5: We recommended that the Executive in Charge for the Office of Management and Chief Financial Officer and VA's General Counsel make a referral to the VA's Procurement Executive for a determination whether any of the service agreements constitute an unauthorized commitment and, if so, take appropriate action to rectify the problem. --

Recommendation 6: We recommended that the Executive in Charge for the Office of Management and Chief Financial Officer and VA's General Counsel immediately determine what services VOA [Volunteers of America] is actually performing and which services VA employees are performing and what services, if any, VA needs from VOA. Consideration should be given to simply leasing the existing space, with VA employees providing all the services, or relocating the domiciliary. --

[redacted]

Recommendation 7: We recommended that the Principal Executive Director for Acquisition, Logistics, and Construction determine the feasibility of creating an electronic interface to allow the price files to be updated with the vendor supplied Excel spreadsheets to eliminate the necessity for manually entering prices. --

Recommendation 8: We recommended that the Principal Executive Director for Acquisition, Logistics, and Construction seek legislative changes that would require manufacturers/dealers/resellers to offer generics on contracts. --

Recommendation 15: We recommended that the Under Secretary for Health and the Principal Executive Director for Acquisition, Logistics, and Construction conduct a study to determine the impact the Trade Agreements Act has in restricting access to generic pharmaceuticals and to what extent waivers or regulatory changes are necessary to ensure adequate product availability. --

[redacted]

Recommendation 2: We recommended that the Assistant Secretary for Operations, Security, and Preparedness, in conjunction with the Assistant Secretary for Information Technology, implement a central case management system to automate the background investigation process and effectively monitor VA contractor status and associated contract costs during the background investigation process. --

[redacted]

Recommendation 1: We recommended the Assistant Secretary for Information and Technology identify VA networks transmitting unprotected sensitive data over unencrypted telecommunication networks and implement technical configuration controls to ensure encryption of such data in accordance with applicable VA and Federal information security requirements. --

[redacted]

Recommendation 2: We recommended that the Acting Assistant Secretary for Human Resources and Administration determine the total salary paid to [redacted] for the 39 days that [redacted] was AWOL [absent without leave] from VA or worked for [redacted] while on sick leave and ensure that a bill of collection is issued to [redacted] for that amount, since [redacted] cannot receive pay for the period of time that [redacted] was absent without authorization. --

[illegible]	
Recommendation 1: We recommended the Under Secretary for Benefits ensure the Pension and Fiduciary Service implements procedures that ensure continued veteran and beneficiary eligibility.	$502,000,000[3]
Recommendation 4: We recommended the Under Secretary for Benefits establish a matching program with Medicaid to automatically identify veterans and beneficiaries that require nursing home adjustments.	
[illegible]	
Recommendation 5: We recommended the Under Secretary for Benefits ensures the Eastern Area Fiduciary Hub implements a plan to expedite completion of their backlog of field examinations to meet performance standards.	--
[illegible]	
Recommendation 1: We recommended the Under Secretary for Benefits take measures to ensure drill pay offsets identified after fiscal year 2012 are timely processed.	$478,500,000
Recommendation 2: We recommended the Under Secretary for Benefits ensure fiscal years 2011 and 2012 drill pay offsets are processed.	$144,600,000
Recommendation 3: We recommended the Under Secretary for Benefits modify existing information technology systems to more effectively monitor, track, and report on drill pay offset activities.	--
[illegible]	
Recommendation 8: We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified.	--
[illegible]	
Recommendation 2: We recommended the Acting Under Secretary for Health establish a directive mandating Workers' Compensation Program specialists implement the workers' compensation guidebook to ensure specialists question the validity of claims lacking adequate supporting evidence.	$11,900,000[4]
[illegible]	
Recommendation 1: We recommended the Under Secretary for Benefits ensure the Post-9/11 G.I. Bill application provides veterans with clear, adequate information on educational benefits and the requirement to relinquish other education benefits before submission.	--

[3] This Better Use of Funds amount was a shared value for Recommendations 1–6 in our report. Only Recommendations 1 and 4 remain open at this time.
[4] This Better Use of Funds amount was a shared value for Recommendations 1 and 2 in our report. Only Recommendation 2 remains open at this time.

Recommendation 5: We recommended the Under Secretary for Benefits ensure Long Term Solution calculations for book stipends align with the regulatory requirements established for students who are enrolled at 50 percent or less.	$205,000,000[5]
[illegible]	
Recommendation 1: We recommended the Under Secretary for Benefits implement a plan to identify all provisionally-rated claims and ensure the proper controls are entered in the electronic system to track, manage, and complete them.	--
Recommendation 2: We recommended the Under Secretary for Benefits implement actions to include provisionally-rated claims in the rating inventory and correct the aging of provisional claims in pending workload statistics.	--
Recommendation 3: We recommended the Under Secretary for Benefits implement a plan to expedite final decisions on all issues in provisionally-rated claims.	--
[illegible]	
Recommendation 2: We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified.	--
[illegible]	
Recommendation 15: We recommended that processes be strengthened to ensure that the medication list provided to the patient/caregiver at discharge is reconciled with the dosage and frequency ordered and that compliance be monitored.	--
[illegible]	
Recommendation 9: We recommended the VA Secretary ensure the Phoenix VA Health Care System follows VA consultation guidance and appropriately reviews consultations prior to closing them to ensure veterans receive necessary medical care.	--
Recommendation 21: We recommended the VA Secretary initiate a process to selectively monitor calls from veterans to schedulers and then incorporate lessons learned into training or performance plans.	--
[illegible]	
Recommendation 1: We recommended the Under Secretary for Benefits improve monitoring to ensure Veterans Affairs Regional Office staff establish claims in the Veteran Benefits Administration's data systems within 7 days of receipt.	--
Recommendation 2: We recommended the Under Secretary for Benefits develop a timeliness standard for Veterans Affairs Regional Office staff making initial requests for service treatment records.	--

[5] This Questioned Costs amount was a shared value for Recommendations 4–8 in our report. Of these four recommendations, only Recommendation 5 remains open at this time.

[redacted]

Recommendation 16: We recommended that the facility implement processes to monitor compliance with colorectal cancer timeliness and patient notification requirements. --

[redacted]

Recommendation 7: We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified. --

Recommendation 8: We recommended that staff provide and document medication counseling/education as required. --

[redacted]

Recommendation 5: We recommended the Interim Under Secretary for Health revise Integrated Oversight Process review procedures to include a review to ensure Advisory and Assistance services are identified and approved. --

[redacted]

Recommendation 1: We recommended that processes be strengthened to ensure that the Critical Care Committee reviews each code episode, that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code, and that code data is collected. --

Recommendation 8: We recommended that the facility develop an acute ischemic stroke policy that addresses all required items, that the policy be fully implemented, and that compliance be monitored. --

Recommendation 9: We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored. --

Recommendation 11: We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored. --

Recommendation 18: We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and that compliance be monitored. --

Recommendation 19: We recommended that processes be strengthened to ensure that secondary patient safety screening forms are scanned into the patients' electronic health records and that compliance be monitored. --

Recommendation 22: We recommended that processes be strengthened to ensure that patients with positive colorectal cancer screening test results receive diagnostic testing within the required timeframe and that compliance be monitored. --

[redacted]

Recommendation 14: We recommended that CBOC/Primary Care Clinic staff document a plan to monitor the alcohol use of patients who decline referral to specialty care. --

Recommendation 15: We recommended that managers ensure that patients with excessive persistent alcohol use receive brief treatment or are evaluated by a specialty provider within 2 weeks of the screening. --

[redacted]

Recommendation 9: We recommended that clinicians provide human immunodeficiency virus testing as part of routine medical care for patients and that compliance is monitored. --

Recommendation 10: We recommended that clinicians consistently document informed consent for human immunodeficiency virus testing and that compliance is monitored. --

[redacted]

Recommendation 8: We recommended that requestors consistently include "inpatient" in the consult title and that facility managers monitor compliance. --

Recommendation 11: We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance. --

Recommendation 12: We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance. --

Recommendation 13: We recommended that the facility collect and report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake. --

Recommendation 15: We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges or scope of practice and that facility managers monitor compliance. --

Recommendation 18: We recommended that the facility consistently schedule follow-up appointments within the timeframes requested by providers. --

[redacted]

Recommendation 1: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, establish procedures to ensure the Office of Product Development completes all required Planning Reviews (repeat recommendation from the 2011 VA Office of Inspector General audit report). --

Recommendation 2: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, ensure personnel performing Compliance Reviews assess the accuracy and reasonableness of cost information reported on the Project Management Accountability System Dashboard (repeat recommendation from the 2011 VA Office of Inspector General audit report). --

Recommendation 3: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, ensure hiring actions are completed by acquiring the vacant Federal employee positions in the Project Management Accountability System Business Office (repeat recommendation from the 2011 VA Office of Inspector General audit report).	$6,400,000[6]
Recommendation 4: We recommended the Assistant Secretary for Information and Technology modify the Project Management Accountability System Dashboard to maintain original baseline data and issue guidance to ensure project performance is measured against both the original and current baselines.	
Recommendation 5: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, complete modification of the Project Management Accountability System Dashboard so that it maintains a complete audit trail of baseline data by including planned, revised, and actual figures for project life-cycle and increment costs (repeat recommendation from the 2011 VA Office of Inspector General audit report).	--
Recommendation 6: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, complete development and implementation of a sound methodology to capture and report planned and actual total project and increment level costs (repeat recommendation from the 2011 VA Office of Inspector General audit report).	--
Recommendation 7: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, ensure project managers capture and report reliable cost data and maintain adequate audit trails to support how the cost information reported on the Project Management Accountability System Dashboard was derived in the interim until actions to automate budget traceability and shift VA's IT projects to increment-based contracts are completed (repeat recommendation from the 2011 VA Office of Inspector General audit report).	--
Recommendation 8: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, clearly define the term "enhancement of an existing system or its infrastructure" and require Service Delivery and Engineering project teams to track and report costs associated with enhancements on the Project Management Accountability System Dashboard.	--
[redacted]	
Recommendation 4: We recommended that Clinic Registered Nurse Care Managers receive motivational interviewing and health coaching training and that providers and clinical associates in the outpatient clinics receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.	--
[redacted]	
Recommendation 39: We recommended that facility managers ensure patient notification of diagnostic test results within the required timeframe and that clinicians document notification.	--

[6] This Better Use of Funds amount was a shared value for Recommendations 3 and 4 in our report. Both recommendations remain open at this time.

32. Audit of VHA's Home Telehealth Program
Report Number [illegible], Issue Date: March 9, 2016

Recommendation 1: We recommended that the Interim Under Secretary for Health implement mechanisms that effectively identify demand for Non-Institutional Care services to ensure that veterans who need these services are provided the opportunity to participate in the Home Telehealth Program. --

Recommendation 2: We recommended that the Interim Under Secretary for Health develop specific performance measures to promote enrollment of Non-Institutional Care patients into the Home Telehealth Program. --

33. Audit of VA's Drug-Free Workplace Program
Report Number 14-02355-125, Issue Date: March 30, 2016

Recommendation 3: We recommended the Deputy Assistant Secretary for Human Resources Management develop procedures to ensure the Drug Testing coding of employees in Testing Designated Positions is accurate and complete in the Personnel and Accounting Integrated Data system. --

34. Healthcare Inspection – Gaps in Access and Quality of Care, VA Maryland Health Care System, Baltimore, Maryland
Report Number [illegible], Issue Date: April [illegible], 2016

Recommendation 2: We recommended that the System Director ensure that a contingency plan for patient aligned care team provider shortages is developed. --

Recommendation 6: We recommended that the System Director ensure that the Access Action Plan for Orthopedic Surgery Services is carried out in an effort to improve access to orthopedic surgical services. --

Recommendation 7: We recommended that the System Director ensure that providers comply with their responsibilities of electronic health record documentation of the community care of co-managed patients. --

35. Review of Alleged Data Manipulation and Mismanagement at the VA Regional Office Philadelphia, Pennsylvania
Report Number [illegible], Issue Date: April 15, 2016

Recommendation 24: We recommended the Under Secretary for Benefits develop and implement a timeliness goal for VA Regional Offices to process returned mail. --

Recommendation 31: We recommended the Under Secretary for Benefits develop and implement a plan that includes a timeliness goal to ensure mail is associated with electronic or paper claims folders prior to claims processing actions. --

Recommendation 35: We recommended the Under Secretary for Benefits conduct an independent review of production standards for Pension Call Center staff to determine if the timeliness standard is reasonable and obtainable without compromising the quality of customer service to callers. --

36. Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Palo Alto Health Care System Palo Alto, California
Report Number [illegible], Issue Date: May [illegible], 2016

Recommendation 2: We recommended that staff protect patient-identifiable information on laboratory specimens during transport from the Fremont CBOC to the parent facility. --

[redacted]

Recommendation 4: We recommended that clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen. --

[redacted]

Recommendation 5: We recommended that the Acting Assistant Secretary for Management perform risk assessments for programs with a high concentration of vendor payments using revised procedures that include contracting risk. --

[redacted]

Recommendation 3: We recommended that the Medical Executive Board and the Facility Director consistently review and approve all privilege forms annually and all revised privilege forms and document the review. --

Recommendation 4: We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have properly approved/signed privilege forms. --

Recommendation 5: We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information. --

Recommendation 8: We recommended that clinicians report all critical incidents through the facility's adverse event reporting process. --

Recommendation 9: We recommended that the facility review the quality of entries in the electronic health record and analyze data at least quarterly. --

Recommendation 11: We recommended that Environment of Care Committee minutes include discussion regarding environment of care rounds deficiencies and that facility managers monitor compliance. --

Recommendation 12: We recommended that facility managers ensure patient care areas and public restrooms are clean and monitor compliance. --

Recommendation 13: We recommended that the facility repair damaged furniture in patient care areas or remove it from service. --

Recommendation 14: We recommended that the facility store oxygen tanks in a manner that distinguishes between empty and full tanks and that facility managers monitor compliance. --

Recommendation 15: We recommended that facility managers ensure all electrical gang boxes have the appropriate covers installed. --

Recommendation 16: We recommended that the facility store clean and dirty items separately and that facility managers monitor compliance. --

Recommendation 17: We recommended that the facility promptly remove outdated commercial supplies from sterile supply rooms and that facility managers monitor compliance. --

Recommendation 18: We recommended that the facility promptly remove expired medications from patient care areas and that facility managers monitor compliance. --

Recommendation 19: We recommended that the facility label medications in accordance with local policy and that facility managers monitor compliance.	--
Recommendation 20: We recommended that the facility inspect alarm-equipped medical devices according to local policy and the manufacturers' recommendations and that facility managers monitor compliance.	--
Recommendation 21: We recommended that the facility document functionality checks of the community living center's elopement prevention system at least every 24 hours and conduct and document annual complete system checks and that facility managers monitor compliance.	--
Recommendation 22: We recommended that the facility inspect and tag critical medical equipment in the community living center and that facility managers monitor compliance.	--
Recommendation 34: We recommended that the facility revise the stroke policy to address a stroke team and data gathering for analysis and improvement and that facility managers fully implement the revised policy.	--
Recommendation 35: We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.	--
Recommendation 36: We recommended that the facility collect and report to the Veterans Health Administration the percent of patients with stroke symptoms who had the stroke scale completed and the percent of patients screened for difficulty swallowing before oral intake.	--
Recommendation 38: We recommended that the facility ensure initial clinician emergency airway management competency assessment includes all required elements and that facility managers monitor compliance.	--
Recommendation 39: We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges or scope of practice and that facility managers monitor compliance.	--
Recommendation 40: We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes completion of all required elements at the time of renewal of privileges or scope of practice and that facility managers monitor compliance.	--
Recommendation 42: We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care and that facility managers monitor compliance.	--
Recommendation 43: We recommended that facility managers strengthen processes to minimize a repeat occurrence in which non-privileged providers perform intubations and in instances of occurrence, initiate root cause analyses.	--
[redacted]	
Recommendation 1: We recommended the Under Secretary for Benefits implement a plan to ensure field examination workload is completed in compliance with timeliness standards.	--
Recommendation 2: We recommended the Under Secretary for Benefits use the percentage of untimely field examinations in addition to the average days pending performance measure to better evaluate completion of field examinations.	--

Recommendation 3: We recommended the Under Secretary for Benefits require hub managers to use Beneficiary and Fiduciary Field System reports to identify and correct unscheduled field examinations at least once per quarter. --

[redacted]

Recommendation 1: We recommended that the Interim Under Secretary for Health ensure that gastroenterology, pathology, nuclear medicine, and radiation oncology program offices define specialty specific criteria or monitors for use in Focused and Ongoing Professional Practice Evaluations and require consistent application across the Veterans Health Administration and that program offices monitor compliance. --

Recommendation 2: We recommended that the Interim Under Secretary for Health require a process to obtain input for evaluating professional practice from another physician in the same specialty when a physician is the only one of any specialty at a facility and require each Veterans Integrated Service Network to monitor compliance. --

[redacted]

Recommendation 5: We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance. --

Recommendation 6: We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance. --

Recommendation 7: We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance. --

Recommendation 8: We recommended that the facility ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that facility managers monitor compliance. --

[redacted]

Recommendation 11: We recommended that clinicians provide human immunodeficiency virus testing as part of routine medical care for patients and that compliance is monitored. --

[redacted]

Recommendation 1: We recommended that the Facility Director ensure that Radiology Department managers confirm that ordered magnetic resonance imaging exams are scheduled and completed within the Veterans Health Administration required timeframe. --

Recommendation 2: We recommended that the Facility Director require Radiology Department managers to review pending lists of magnetic resonance imaging exams at designated intervals to ensure timely scheduling of these exams and that compliance be monitored. --

[redacted]

Recommendation 4: We recommended that the Veterans Integrated Service Network Director ensure that the Facility Director provide appropriate and timely neurosurgical consultation services to patients receiving care at the facility consistent with Veterans Health Administration Directive 2008-056, VHA Consult Policy, September 16, 2008. --

[redacted]

Recommendation 4: We recommended the Deputy Under Secretary for Health for Operations and Management confer with the Office of Human Resources and the Office of General Counsel to determine the appropriate administrative action to take, if any, against Chief Business Office officials for directing the misuse of approximately $43.1 million of fiscal year 2011 appropriated funds. --

[redacted]

Recommendation 2: We recommended the Facility Director reevaluate and make the appropriate changes to the methods for referring patients for mental health care, including the extent to which the consult package is being used appropriately. --

Recommendation 3: We recommended the Facility Director ensure that mental health consults are reviewed and closed in accordance with Veterans Health Administration policy. --

Recommendation 4: We recommended the Facility Director ensure that Veterans Health Administration appointment scheduling guidance is followed and that schedulers utilize the electronic waiting list and give priority to service connected veterans, as appropriate. --

[redacted]

Recommendation 3: We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility leaders, ensure that nursing employees provide and document restorative nursing services in accordance with the care plan, and if they do not provide the services, they document the reason. --

Recommendation 4: We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility leaders, ensure that employees complete required restorative summary notes and that the Associate Chief Nurse or designee monitors compliance. --

[redacted]

Recommendation 2: We recommended the Interim Under Secretary for Health revise policies, if necessary, when a definitive legal position is provided on Grant and Per Diem Program eligibility. --

Recommendation 3: We recommended the Interim Under Secretary for Health implement controls to ensure grant applications comply with the definitive legal position on Grant and Per Diem Program eligibility. --

60. Combined Assessment Program Review of the Central Texas Veterans Health Care System, [illegible] **Report Number: 16-00364-[illegible] Issue Date: July 15, 2016**	
Recommendation 4: We recommended that the facility consistently document actions when data analyses indicated problems or opportunities for improvement and evaluate them for effectiveness in the Quality, Safety, and Value; Critical Care; Medical Records; and Infection Prevention and Control Committees and in the Environment of Care Council.	--
61. Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Central Texas [illegible] **Report Number: 16-00392-[illegible] Issue Date: July 27, 2016**	
Recommendation 2: We recommended that clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.	--
Recommendation 3: We recommended that clinic staff provide education and counseling for patients with positive alcohol screens and alcohol consumption above National Institute on Alcohol Abuse and Alcoholism limits.	--
Recommendation 5: We recommended that Clinic Registered Nurse Care Managers receive motivational interviewing training within 12 months of appointment to Patient Aligned Care Teams.	--
62. Healthcare Inspection – Mental Health-Related Patient Deaths and Inadequate Leadership Responsiveness, Central Alabama VA Health Care System, Montgomery, AL **Report Number: 15-04530-[illegible] Issue Date: July 27, 2016**	
Recommendation 1: We recommended that the Central Alabama VA Health Care System Director ensure adequate mental health staffing in the community based outpatient clinics to provide timely and appropriate patient care.	--
Recommendation 2: We recommended that the Central Alabama VA Health Care System Director ensure appropriate review and scheduling of patients on the electronic wait list and Recall Reminder lists provided to management.	--
Recommendation 6: We recommended that the Central Alabama VA Health Care System Director ensure that staff receive appropriate training on the policy requirements for managing disruptive behavior.	--
Recommendation 7: We recommended that the Central Alabama VA Health Care System Director ensure that the Disturbed Behavior Committee complies with policy on completing and documenting incident/threat assessments and initiating Patient Record Flags.	--
Recommendation 8: We recommended that the Central Alabama VA Health Care System Director ensure that all Disturbed Behavior Committee Alert Notes, both recent and remote, have been reviewed and appropriate actions taken, if indicated.	--
Recommendation 10: We recommended that the Central Alabama VA Health Care System Director evaluate options available to improve the timeliness of Emergency Department clearance and acute mental health unit admission for high risk patients.	--
Recommendation 11: We recommended that the Central Alabama VA Health Care System Director ensure that mental health providers adequately document their clinical reasoning when their treatment decisions do not comply with VA/DoD guidelines for medication management in Post-Traumatic Stress Disorder and Substance Use Disorder patients.	--

Recommendation 12: We recommended that the Central Alabama VA Health Care System Director approve and issue a Mental Health Treatment Coordinator policy and train appropriate staff on same.	--
Recommendation 13: We recommended that the Central Alabama VA Health Care System Director ensure assignment of Mental Health Treatment Coordinators for all appropriate patients.	--
Recommendation 14: We recommended that the Central Alabama VA Health Care System Director monitor to ensure the Dothan Primary Care contractor complies with staffing and care specifications as outlined in the contract.	--
Recommendation 15: We recommended that the Central Alabama VA Health Care System Director ensure that the Dothan Primary Care contract complies with Veterans Health Administration policy on the treatment of uncomplicated psychiatric disorders.	--
Recommendation 17: We recommended that the Central Alabama VA Health Care System Director reinitiate ongoing professional practice evaluation-related mental health chart reviews.	--
53. Healthcare Inspection – [illegible] Management, Contract, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama Report Number: [illegible], Issue Date: July [illegible], 2015	
Recommendation 1: We recommended that the Under Secretary for Health provide consistent interim leadership to Central Alabama Veterans Health Care System in the form of highly skilled leaders who can lead systemic improvements and cultural change until such time as the leadership positions can be filled permanently.	--
Recommendation 2: We recommended that the Under Secretary for Health directly monitor corrective actions taken to remedy the deficiencies identified in this report and routinely assess their effectiveness at least annually for a period of 3 years.	--
Recommendation 3: We recommended that interim Central Alabama Veterans Health Care System leadership begin, and permanent leadership continue, to make systemic improvements to the Non-VA Care Coordination consult process, to include ensuring that patients receive services timely; that the backlog is resolved; that staff comply with business rules governing the process; and that the program is provided with adequate staffing, training, and a consistent leadership structure.	--
Recommendation 7: We recommended that the interim Central Alabama Veterans Health Care System leadership ensure that all previously chartered Administrative Boards of Investigations have been conducted and finalized to include documentation of decision for final action(s), evidence that actions have been implemented and/or addressed, and appropriate certification of completion per Veterans Health Administration guidelines.	--
54. Review of Alleged Mismanagement of VHA's Service-Oriented Architecture Research and Development Pilot Project Report Number: [illegible]-43, Issue Date: August 5, 2015	
Recommendation 2: We recommended the Under Secretary for Health remedy all Medical Support and Compliance appropriations used to pay for Service-Oriented Architecture Research and Development.	$2,600,000
55. Inspection of VA Regional Office St. Petersburg, Florida Report Number: 15-00001-[illegible], Issue Date: August 26, 2015	
Recommendation 2: We recommended the Under Secretary for Benefits direct Veterans Benefits Administration field offices prioritize processing reminder notifications within 30 days as required.	--

Recommendation 5: We recommended the St. Petersburg VA Regional Office Director implement a plan to ensure oversight and prioritization of benefits reductions cases. --

Recommendation 6: We recommended the Under Secretary for Benefits direct Veterans Benefits Administration field offices to prioritize benefits reductions cases in order to minimize overpayments. --

[redacted]

Recommendation 2: We recommended the Under Secretary for Benefits retroactively establish debts for all fiduciaries who VBA determined misused beneficiary funds during calendar year 2013. --

Recommendation 3: We recommended the Under Secretary for Benefits revise policy to include clear timeliness standards from the time the hubs determine misuse occurred to the time Pension and Fiduciary Service completes the negligence determination. --

Recommendation 4: We recommended the Under Secretary for Benefits ensure the processing of all misuse actions are incorporated into quality reviews of Fiduciary Program operations. --

[redacted]

Recommendation 3: We recommended that clinic staff provide education and counseling for patients with positive alcohol screens and alcohol consumption above National Institute on Alcohol Abuse and Alcoholism limits. --

[redacted]

Recommendation 6: We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance. --

Recommendation 8: We recommended that facility managers comply with Veterans Health Administration directive requirements for exempted facilities, or if facility managers plan emergency intubation responses with onsite employees, they comply with Veterans Health Administration requirements for non-exempted facilities. --

[redacted]

Recommendation 4: We recommended that Clinic Registered Nurse Care Managers, providers, and clinical associates receive health coaching training within 12 months of appointment to Patient Aligned Care Teams. --

[redacted]

Recommendation 3: We recommended the Under Secretary for Health develop and execute a project management plan to ensure that Enrollment System data are fully evaluated and properly categorized. --

Recommendation 4: We recommended the Under Secretary for Health implement controls to ensure that future enrollment data are accurate and reliable before being entered in the Enrollment System. --

Recommendation 5: We recommended the Under Secretary for Health implement effective policies and procedures to accurately and timely identify deceased individuals with records in the Enrollment System and record their changed status in the system.	--
Recommendation 6: We recommended the Under Secretary for Health establish appropriate policies and procedures to ensure Health Eligibility Center workload data are not deleted or changed without appropriate management review, approval, and audit trails.	--
Recommendation 8: We recommended the Under Secretary for Health confer with the Office of Human Resources and the Office of General Counsel to fully evaluate the implications of the first three allegations, determine if administrative action should be taken against any senior Veterans Health Administration officials involved, and ensure that appropriate action is taken.	--
[redacted]	
Recommendation 1: We recommended the Executive in Charge for the Office of Information and Technology, in conjunction with the Under Secretary for Benefits, implement improved cost controls and stabilize Veterans Benefits Management System functionality requirements for the remainder of planned system development to restrict further cost increases.	--
Recommendation 3: We recommended the Executive in Charge for the Office of Information and Technology perform market analyses on all future Space and Naval Warfare Systems Command Atlantic task orders to determine whether the continued use of the interagency agreements is in the best interest of the Department.	--
Recommendation 4: We recommended the Executive in Charge for the Office of Information and Technology, in conjunction with the Under Secretary for Benefits, establish a clear strategy and plan to decommission legacy systems, eliminate redundant systems operations, and reduce system maintenance costs.	$27,000,000
[redacted]	
Recommendation 3: We recommended that clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.	--
Recommendation 4: We recommended that clinic staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.	--
[redacted]	
Recommendation 2: We recommended the Deputy Secretary review the Department's request and approval process for temporary quarters subsistence expense allowance and make improvements as deemed appropriate.	--
Recommendation 4: We recommended the Deputy Secretary strengthen the approval process to include requiring an independent review of the Department's Permanent Change of Station program to ensure moves and expenses are appropriate and justified.	--
Recommendation 5: We recommended the Deputy Secretary require the Veterans Benefits Administration to establish policies and procedures to standardize its practices regarding annual salary increases when reassigning Senior Executives' positions.	--

Recommendation 7: We recommended the Deputy Secretary consult with the Office of General Counsel to determine what actions may be taken to hold the appropriate Senior Officials accountable for processing and approving payments of unjustified relocation incentive payments.	--
[redacted]	
Recommendation 5: We recommended the Under Secretary for Health require the input of National Provider Identifier information for rendering providers in the Fee Basis Claims System to ensure adequate data are available for program evaluation and planning.	--
[redacted]	
Recommendation 1: We recommend that the Director, VA Heart of Texas Health Care Network (VISN 17) and the Director, VANTHS [VA North Texas Health Care System] take immediate steps to prioritize awarding a long-term contract for CT [cardiothoracic] surgery and perfusion services that is fully compliant with VA Directive 1663.	--
Recommendation 2: We recommend that the Director, VA Heart of Texas Health Care Network (VISN 17) and the Director, VANTHS take immediate steps to recruit a full-time or part-time CT surgeon(s).	--
Recommendation 3: We recommend that the Director, VA Heart of Texas Health Care Network (VISN 17) and the Director, VANTHS take immediate steps to recruit a VA perfusionist(s).	--
Recommendation 5: We recommend that the Director, VA Heart of Texas Health Care Network (VISN 17) and the Director, VANTHS take immediate steps to determine status and compliance related to all healthcare contracts and services provided by UTSW [University of Texas Southwestern Medical Center] at VANTHS.	--
[redacted]	
Recommendation 4: We recommended that hand hygiene compliance is monitored at the American Samoa VA Clinic and reported to the Infection Control Committee.	--
Recommendation 14: We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.	--
[redacted]	
Recommendation 4: We recommended the Under Secretary for Health complete a review of TriWest's performance and apply penalties if it is determined there is a lack of performance related to the timely return of clinical documentation.	$5,768,597[7]

[7] This amount is derived from a Better Use of Funds amount of $257,652 shared between Recommendations 1 and 4 in our report, as well as a Questioned Costs amount of $5,510,945 shared between Recommendations 1 and 4 ($257,652 + $5,510,945 = $5,768,597). Of these two recommendations, only Recommendation 4 remains open at this time.

Recommendation 5: We recommended the Under Secretary for Health review the contract disincentives applied to HealthNet and determine if additional funds need to be recouped from the contractor and pursue collection if disincentives were under applied. --

Recommendation 7: We recommended the Under Secretary for Health implement procedures to verify whether Patient-Centered Community Care contractors and their network providers correctly and timely report critical findings to VA and impose financial penalties or other remedies when contractors fall below the contract performance threshold. --

[redacted]

Recommendation 4: We recommended that the Special Care Unit Committee review each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code. --

Recommendation 7: We recommended that facility managers ensure patient care areas are clean and damaged wall surfaces are repaired and monitor compliance. --

Recommendation 10: We recommended that facility managers ensure monthly medication storage area inspections are completed and monitor compliance. --

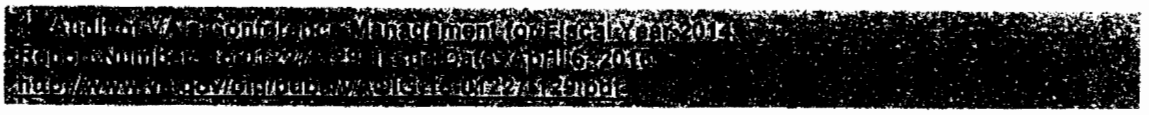
[redacted]

Recommendation 5: We recommended the Interim Director of Veterans Integrated Service Network 3 conduct a review and consult appropriate VA offices, including the Office of General Counsel, to determine whether administrative action is appropriate for those officials in the Engineering, Environmental Management, and Human Resources Services who did not adequately review or correct employees' official duty stations in response to the 2014 Office of Human Resources and Administration's request for verification of all employees' official duty stations. --

[redacted]

APPENDIX B

AGENCY MANAGEMENT DISAGREEMENT WITH OIG RECOMMENDATIONS ISSUED DURING THE REPORTING PERIOD APRIL 1–SEPTEMBER 30, 2016



Recommendation 5: We recommended the Interim Assistant Secretary for Management update existing policy to reinstate the Conference Certifying Official as the reviewer of the Conference Package instead of the Responsible Conference Executive.

VA Response: Non-concur

VA Comments: The revised conference policy, VA Financial Policies and Procedures, Volume XIV, Travel, Chapter 10, Conference Planning, Reporting and Oversight, March 2015, was streamlined to ensure accountability was placed with a single individual responsible for planning and executing conferences. The prior Conference Certifying Official review functions were similar to the Responsible Conference Executive functions and created unnecessary duplication and confusion regarding who had accountability over the conference. Instituting a single review official is a more efficient process, and increases the ability of the Department to hold a single individual accountable for conference planning and execution.

OIG Response: The Interim Assistant Secretary concurred with the intent of Recommendations 1 through 4, but did not concur with Recommendations 5 and 6. However, the Interim Secretary provided action plans that, if implemented, should address our concerns identified in the six recommendations.

In regard to Recommendation 5, the Interim Assistant Secretary for Management's response to Recommendation 3 would require VA organizations to establish compliance review procedures for planned and executed conferences within their organization. If the VA organizations' procedures maintain the separation of duties between the individual performing the compliance review and the Responsible Conference Executive, we would consider these actions sufficient to close this recommendation.

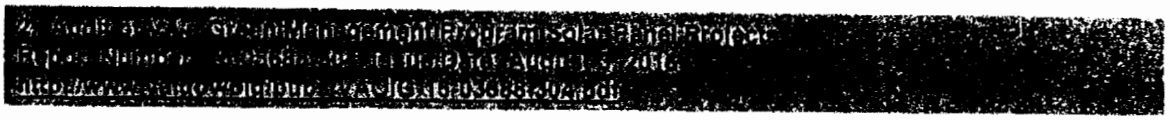
Recommendation 6: We recommended the Interim Assistant Secretary for Management update existing policy to reinstate the Corporate Travel Reporting Office review of Conference Packages with a budget of $100,000 or more before submitting the package for Deputy Secretary or Secretary approval.

VA Response: Non-concur

VA Comments: The revised conference policy, VA Financial Policies and Procedures, Volume XIV, Travel, Chapter 10, Conference Planning, Reporting and Oversight, March 2015, was streamlined to ensure that accountability was placed with a single individual responsible for planning and executing conferences, and to place responsibility for the quality of the packages on the Administrations and Staff Offices. Additionally, since implementation of the new policy, we have instituted reviews of completed conference packages, and our reviews do not indicate that the prior Corporate Travel Reporting Office review process requires reinstatement at this time.

OIG Response: The Interim Assistant Secretary concurred with the intent of Recommendations 1 through 4, but did not concur with Recommendations 5 and 6. However, the Interim Secretary provided action plans that, if implemented, should address our concerns identified in the six recommendations.

In regard to Recommendation 6, the Interim Assistant Secretary stated the Office of Finance will perform compliance reviews of VA organizations' Conference Packages and Final Conference Reports. Once the Office of Finance fully implements the new review procedures, we would consider these actions to be sufficient to close this recommendation.



Recommendation 2: We recommended the Interim Assistant Secretary for Management identify and share best practices for executing timely interconnection agreements with utilities based on continued collaboration with other Federal agencies.

VA Response: Non-concur

VA Comments: VA has, and continues, to collaborate with other Federal agencies to promote best practices in this area. However, through these efforts, we learned that each Federal agency's handling of the interconnection agreements is specific to an agency and does not lend itself to a universal best practice that fits all. Utility interconnection agreements are regulated at the state level and each utility company has different requirements. To date, many utility companies are unfamiliar with pertinent Federal contracting requirements. As a result, the interconnection agreements they present to VA for execution often contain boilerplate provisions that we cannot agree to. For example, their interconnection agreements often contain provisions that would require VA to indemnify the utility company for any injury to persons or damages that the VA energy equipment might cause to the utility company's infrastructure. VA cannot agree to such indemnity provisions, because that would constitute an open-ended obligation that would violate the Anti-Deficiency Act (31U.S.C. §§ 1341, 1342, 1351, and 1517). Accordingly, the U.S. Department of Justice has specifically instructed VA to use the following alternative language in Interconnection Agreements: "The liability, if any, of the United States for injury or loss of property, or personal injury or death shall be governed exclusively by the provisions of the Federal Tort Claims Act (28 USC 2671-2680)." Another example of unacceptable boilerplate language occurs when utility companies seek to have State and local law control in Interconnection Agreements. For obvious reasons, VA must require to have the agreement made subject to applicable law, which in many instances would include Federal law. When impasses occur on such issues when negotiating interconnection agreements with utility companies, VA on occasion must seek relief through the local public utility commissions, to request appropriate changes to unacceptable boilerplate language in underlying interconnection agreements. VA will continue to share its experiences with Federal agencies, and work with utilities – and where necessary – with state regulatory bodies, to ensure that interconnection agreements are in compliance with Federal requirements.

OIG Response: The Interim Assistant Secretary for Management non-concurred with Recommendations 2 and 4. For Recommendation 2, OM stated VA continues to collaborate with other Federal agencies and highlighted the challenges of applying standard state and utility provisions in interconnection agreements. In addition, they highlighted that each Federal agency handles interconnection agreements different which does not lend itself to a universal best practice. VA stated they will continue to share its experiences with Federal agencies, and work with utilities – and where necessary – with state regulatory bodies, to ensure that interconnection agreements are in compliance with Federal requirements.

The Interim Assistant Secretary for Management response to Recommendation 2 non-concurred with our recommendation. While we acknowledge the challenges VA has presented, our recommendation is intended to emphasize the importance of continuing to identify additional best practices gained from working with utilities and states to further reduce the time to execute interconnection agreements.

Recommendation 4: We recommended the Interim Assistant Secretary for Management conduct a lessons learned assessment for solar project delays and implement additional controls to ensure future solar panel projects are properly planned and managed.

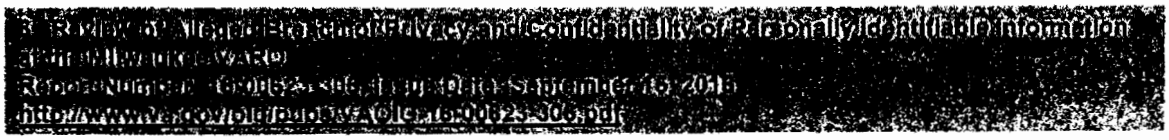
VA Response: Non-concur

VA Comments: OM disagrees that additional lessons-learned analyses are required at this time. VA is a continuously learning organization and lessons learned are constantly shared through our ongoing

communication through conference calls, interaction with the field, and other means of communication. In fact, over the past two years, GMP and PCAC have instituted a number of changes to the way solar PV projects are planned, procured, and managed, including more comprehensive economic and technical analysis, greater coordination with VISN and medical center leadership, and changes to performance specifications and contract clauses. For example, in its awards for solar PV systems at Las Vegas and Houston in FY 2014 and FY 2015, GMP and PCAC changed the method by which the projects were solicited, resulting in clearer objectives and scope, and greater competition. VA believes that had OIG considered a representative array of projects, these changes would be reflected in the report. GMP has also appointed region-specific points of contact for solar projects to help ensure optimal planning and management. As a result, VA believes that the concerns raised in this report have been successfully resolved or mitigated.

OIG Response: The Interim Assistant Secretary for Management non-concurred with Recommendations 2 and 4. For Recommendation 4, OM stated that additional lessons-learned analysis was not necessary as they are constantly sharing information and lessons learned are shared through ongoing communications. OM stated that over the past 2 years, GMP and PCAC have instituted a number of changes to the way solar PV projects are planned, procured, and managed, including more comprehensive economic and technical analysis, greater coordination with VISN and medical center leadership, and changes to performance specifications and contract clauses.

The Interim Assistant Secretary for Management non-concurred with Recommendation 4. We requested GMP provide us with a formal lessons learned assessment during our March 2016 exit briefing when we were made aware that this assessment may have occurred. GMP provided us with a one-page document which indicated that a contract was awarded in 2014-2015 to strategically assess how solar panel projects were performing, where improvements could be made, and how lessons learned could be applied towards future projects. However, no operational improvements were detailed in the document and key challenges for solar panel delays such as contractor delays were not addressed. A formal lessons learned assessment conducted periodically for all current WIP and future projects will help identify process improvements and minimize future program delays.



Recommendation 1: We recommended the VA Assistant Secretary for Information and Technology improve VA's email security filtering software configuration controls to effectively flag improper transmissions of veterans' personally identifiable information over the VA network.

VA Response: Non-concur

VA Comments: Regarding the incident referenced in your draft report, VA's position on this incident is unchanged since our February 2, 2016, response to Senator Johnson, Chairman, U.S. Senate Committee on Homeland Security and Governmental Affairs. I have reviewed your four recommendations and believe that all policy, procedures, and required training are already in place. VA Handbook 6500, Risk Management Framework for VA Information Systems and all users of VA IT systems, and/or those having access to sensitive information, must be enrolled in the Talent Management System (TMS), and complete the VA Privacy and Information Security Awareness Training and Rules of Behavior (VA 10176) on an annual basis. I will be sending the attached memorandum to all VA executive leaders to remind them of importance of completing the mandatory training, but also to stress to them that information security must be incorporated into all VA processes and procedures.

VA has strengthened the calibration in the scanning tool to include additional words and phrases that will expand the capability to detect PII. However, blocking all nine digit numeric patterns without additional factor matching is impracticable, as other non-PII nine digit numeric patterns are necessary for daily VA

support, such as ticket numbers, file tracking, and Outlook meetings notifications. While this re-calibration will result in more "false-positives," VA attempts to manage risk by taking a measured approach, but will always defer on the side of information security.

OIG Response: The Assistant Secretary for Information and Technology non-concurred with all four recommendations and stated that VA's position was unchanged since its response in February 2016 to the Senate Committee on Homeland Security and Governmental Affairs (included as Attachment 2 of the memo from the Assistant Secretary for Information and Technology – Appendix B of this report). According to the Interim Chief of Staff who signed the response, it was perfectly legal for VA to provide WDVA a spreadsheet of recently closed claims that contained 638 veterans' names and SSNs. The Interim Chief of Staff also stated that the event regarding the improper transmission of Wisconsin veterans' PII did not represent a breach or failure on the part of VA. Instead, the Interim Chief of Staff stated it was an inadvertent release of PII that resulted from human error for which WDVA accepted responsibility.

The Assistant Secretary believed that all policies, procedures, and required training were already in place. Furthermore, she went on to state that a memo would be sent to all VA executive leaders reminding them of the importance of completing the annual mandatory VA Privacy and Information Security Awareness training and stressing that information security must be incorporated into all VA processes and procedures. As a result, the Assistant Secretary requested closure of Recommendations 1 through 4. We disagree with OI&T's assertion that the improper dissemination of veterans' PII over VA's email server to unauthorized recipients was not a data breach and that adequate controls were already in place. We never had an issue with whether VA's sharing of information about veterans' claims with WDVA was legal. Our concern is whether VA's data governance approach was effective in ensuring that third-party organizations adequately controlled and protected veterans' PII. VA does not address the important point that leaving third-party organizations responsible for data governance without coordinated VA oversight has proven ineffective.

Although the Assistant Secretary non-concurred with Recommendation 1, her response stated that VA's email filtering software was updated and strengthened to flag the improper dissemination of veterans' PII over the VA network. Specifically, VA strengthened the calibration in the scanning tool to include additional words and phrases that expanded the capability to detect PII. In addition to strengthening the scanning tool, there will be an ongoing effort by OI&T's security staff to analyze traffic traversing VA's boundary to identify potential SSNs embedded in transmissions. This effort will help the security staff build custom filters to limit the risk of inappropriate data transmissions. The actions taken to improve VA's email filtering software and the ongoing analysis of email transmissions to identify potential scenarios that could compromise veteran's PII addressed Recommendation 1. Therefore, we determined the evidence provided was sufficient to close Recommendation 1.

Recommendation 2: We recommended the VA Assistant Secretary for Information and Technology establish formal agreements with third-party organizations that define network responsibilities, processes, and procedures for handling sensitive veterans' information, and require that information security controls be implemented commensurate with VA's information security standards.

VA Response: Non-concur

VA Comments: OI&T response to this recommendation is addressed in Recommendation 1.

OIG Response: The Assistant Secretary for Information and Technology non-concurred with all four recommendations and stated that VA's position was unchanged since its response in February 2016 to the Senate Committee on Homeland Security and Governmental Affairs (included as Attachment 2 of the memo from the Assistant Secretary for Information and Technology – Appendix B of this report). According to the Interim Chief of Staff who signed the response, it was perfectly legal for VA to provide WDVA a spreadsheet of recently closed claims that contained 638 veterans' names and SSNs. The Interim Chief of Staff also stated that the event regarding the improper transmission of Wisconsin veterans' PII did not represent a breach or failure on the part of VA. Instead, the Interim Chief of Staff

stated it was an inadvertent release of PII that resulted from human error for which WDVA accepted responsibility.

The Assistant Secretary believed that all policies, procedures, and required training were already in place. Furthermore, she went on to state that a memo would be sent to all VA executive leaders reminding them of the importance of completing the annual mandatory VA Privacy and Information Security Awareness training and stressing that information security must be incorporated into all VA processes and procedures. As a result, the Assistant Secretary requested closure of Recommendations 1 through 4. We disagree with OI&T's assertion that the improper dissemination of veterans' PII over VA's email server to unauthorized recipients was not a data breach and that adequate controls were already in place. We never had an issue with whether VA's sharing of information about veterans' claims with WDVA was legal. Our concern is whether VA's data governance approach was effective in ensuring that third-party organizations adequately controlled and protected veterans' PII. VA does not address the important point that leaving third-party organizations responsible for data governance without coordinated VA oversight has proven ineffective.

For Recommendations 2 through 4, the Assistant Secretary did not directly address the recommendations but instead referenced her response to Recommendation 1, which stated that VA's position was unchanged since their February 2016 response to the Senate Committee on Homeland Security and Governmental Affairs. However, for Recommendation 2, the report clearly shows VA does not maintain adequate policies and procedures over VSOs authorized to use VA's network. For example, because WDVA used VA's network to transmit veterans' information to CVSOs and TVSOs, the VARO should have established an MOU with third-party organizations to help with transparency and clearly define information security requirements, network architecture, types of data exchanged, and appropriate roles and responsibilities. In addition, an MOU is one means of documenting data sharing agreements and ensuring VA partners institute information security controls commensurate with VA standards.

Recommendation 3: We recommended the VA Assistant Secretary for Information and Technology evaluate whether permanent encryption controls are needed for non-VA employees who maintain VA accounts for conducting business on behalf of veterans.

VA Response: Non-concur

VA Comments: OI&T response to this recommendation is addressed in Recommendation 1.

OIG Response: The Assistant Secretary for Information and Technology nonconcurred with all four recommendations and stated that VA's position was unchanged since its response in February 2016 to the Senate Committee on Homeland Security and Governmental Affairs (included as Attachment 2 of the memo from the Assistant Secretary for Information and Technology – Appendix B of this report). According to the Interim Chief of Staff who signed the response, it was perfectly legal for VA to provide WDVA a spreadsheet of recently closed claims that contained 638 veterans' names and SSNs. The Interim Chief of Staff also stated that the event regarding the improper transmission of Wisconsin veterans' PII did not represent a breach or failure on the part of VA. Instead, the Interim Chief of Staff stated it was an inadvertent release of PII that resulted from human error for which WDVA accepted responsibility.

The Assistant Secretary believed that all policies, procedures, and required training were already in place. Furthermore, she went on to state that a memo would be sent to all VA executive leaders reminding them of the importance of completing the annual mandatory VA Privacy and Information Security Awareness training and stressing that information security must be incorporated into all VA processes and procedures. As a result, the Assistant Secretary requested closure of Recommendations 1 through 4.

We disagree with OI&T's assertion that the improper dissemination of veterans' PII over VA's email server to unauthorized recipients was not a data breach and that adequate controls were already in place. We never had an issue with whether VA's sharing of information about veterans' claims with WDVA was legal. Our concern is whether VA's data governance approach was effective in ensuring that third-party

organizations adequately controlled and protected veterans' PII. VA does not address the important point that leaving third-party organizations responsible for data governance without coordinated VA oversight has proven ineffective.

Regarding Recommendation 3, the Assistant Secretary did not provide support for why permanent encryption controls were not needed for non-VA employees who maintained VA accounts to conduct VA business. Non-VA employees, such as WDVA employees, maintained their own State email accounts, in addition to maintaining VA email accounts. We maintain our position that permanent encryption controls on VA accounts for non-VA employees would be a reasonable added control to protect against the improper dissemination of veterans' PII.

Recommendation 4: We recommended the VA Assistant Secretary for Information and Technology conduct reviews of processes, procedures, and controls in place at VA regional offices that collaborate with third-party organizations to ensure security of sensitive veterans' information.

VA Response: Non-concur

VA Comments: OI&T response to this recommendation is addressed in Recommendation 1.

OIG Response: The Assistant Secretary for Information and Technology non-concurred with all four recommendations and stated that VA's position was unchanged since its response in February 2016 to the Senate Committee on Homeland Security and Governmental Affairs (included as Attachment 2 of the memo from the Assistant Secretary for Information and Technology – Appendix B of this report). According to the Interim Chief of Staff who signed the response, it was perfectly legal for VA to provide WDVA a spreadsheet of recently closed claims that contained 638 veterans' names and SSNs. The Interim Chief of Staff also stated that the event regarding the improper transmission of Wisconsin veterans' PII did not represent a breach or failure on the part of VA. Instead, the Interim Chief of Staff stated it was an inadvertent release of PII that resulted from human error for which WDVA accepted responsibility.

The Assistant Secretary believed that all policies, procedures, and required training were already in place. Furthermore, she went on to state that a memo would be sent to all VA executive leaders reminding them of the importance of completing the annual mandatory VA Privacy and Information Security Awareness training and stressing that information security must be incorporated into all VA processes and procedures. As a result, the Assistant Secretary requested closure of Recommendations 1 through 4.

We disagree with OI&T's assertion that the improper dissemination of veterans' PII over VA's email server to unauthorized recipients was not a data breach and that adequate controls were already in place. We never had an issue with whether VA's sharing of information about veterans' claims with WDVA was legal. Our concern is whether VA's data governance approach was effective in ensuring that third-party organizations adequately controlled and protected veterans' PII. VA does not address the important point that leaving third-party organizations responsible for data governance without coordinated VA oversight has proven ineffective.

For Recommendations 2 through 4, the Assistant Secretary did not directly address the recommendations but instead referenced her response to Recommendation 1, which stated that VA's position was unchanged since their February 2016 response to the Senate Committee on Homeland Security and Governmental Affairs. Recommendation 4, concerned conducting reviews of processes, procedures, and controls in place at VAROs that collaborate with third-party organizations to ensure security of sensitive veterans' information. Even though WDVA accepted responsibility for improperly disseminating veterans' PII in April 2015, VA was responsible for ensuring information system controls, and all users of the VA network protect veterans' PII and other sensitive information at all levels, including third-party organizations. While it was legal for the VARO to send a monthly disability claims report to WDVA recipients, the VARO discontinued the practice of sending the report to WDVA after the data breach occurred. The action taken by the VARO did not negatively affect WDVA's ability to help veterans facilitate the timely adjudication of their disability claims filed with VA. While non-VA users must maintain

a heightened and constant awareness of their responsibilities regarding the protection of VA information, VA Handbook 6500 states that VA must achieve the Gold Standard in data security. According to VA Handbook 6500, the Gold Standard requires that VA information and information system users protect VA information and information systems, especially the personal data of veterans, their family members, and employees. Achieving the Gold Standard means going beyond what is simply legal to conducting routine reviews of processes, procedures, and controls to ensure data security.

Recommendation 8: We recommended the Acting Under Secretary for Benefits Review the identified missed recoupments to determine if collections would be appropriate and reasonable.

VA Response: Non-concur

VA Comments: Based on a review of the sample cases OIG submitted to VBA, all case reviews were completed. Based on OIG's criteria for missed recoupments, VBA does not believe these cases should be categorized as missed recoupments. OIG identified missed recoupments as course withdrawals and reductions, and repeated courses. The opinion provided by VA's Office of General Counsel (OGC), issued February 10, 2016, in regard to the limitations imposed by 38 U.S.C. § 3680 found that VBA's policy is in accordance with the law regarding repeated courses (Attachment B). In addition, VA implemented system changes to address course reductions and withdrawals (mitigating circumstances) in November 2015. Prior to this time, VA implemented a policy on how to address mitigating circumstances in order to overcome the system challenges. Education claims processed prior to November 2015 should not be identified as missed recoupments or improper payments.

OIG Response: In a March 23, 2016, response to the OIG, the former Acting Under Secretary for Benefits concurred or concurred in principle with seven of the report's eight recommendations, but only provided corrective action plans to address five of these recommendations. We considered these action plans acceptable and will follow up on their implementation. The former Acting Under Secretary for Benefits did not provide adequate action plans for three recommendations—two where he concurred in principle and one where he non-concurred. The former Acting Under Secretary specifically non-concurred with the OIG's recommendation to review the identified missed recoupments for possible collections. The three recommendations without action plans will remain open until the OIG and VBA can resolve the various issues VBA has related to the OIG's findings.

The former Acting Under Secretary for Benefits and VBA generally did not agree with the OIG's findings related to the number and amounts of improper payments and missed recoupments and the estimates derived from the OIG's sampling results. VBA disagreed with the OIG's identification of 43 payments totaling just under $77,700 in improper payments or essentially almost every improper payment we identified that was not a duplicate payment. Moreover, VBA disagreed with all 39 overpayments totaling $96,400 in missed recoupments.

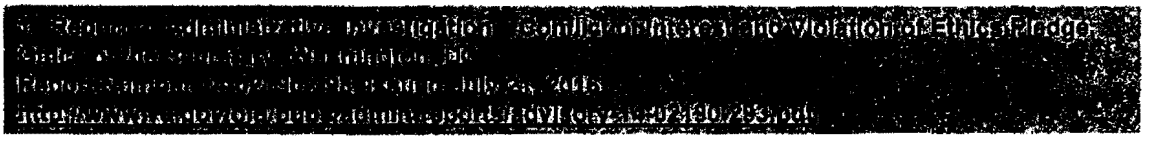
After we received the former Acting Under Secretary's response, we reviewed OMB Circular A-123 and other relevant legal authorities, considered improper payments reporting practices at VA and other agencies, conferred with OMB, and thoroughly reviewed and considered VBA's comments and response. After taking these steps, we reaffirmed our findings. We did not make the suggested report changes VBA provided in the technical comments section of its response (Appendix E), but we did add a more detailed discussion and explanation of our position regarding VBA's November 2015 LTS policy update regarding mitigating circumstances.

In our review of the VA position paper, we found that VBA's responses regarding its review of the 85 identified improper payments and missed recoupments did not provide sufficient evidence for us to revise our findings. In addition, we disagreed with VBA's interpretation and application of various statutes and

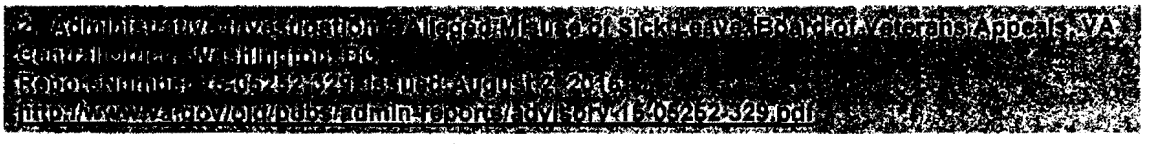
policies related to book fees and repeated classes. After the retirement of the former Acting Secretary for Benefits, we met with the Principal Deputy Under Secretary for Benefits to discuss the VBA's response and to give him the opportunity to reconsider the response and/or provide additional information for us to consider. He demurred and opted to stand by the positions in VBA's March 23, 2016 response.

APPENDIX C

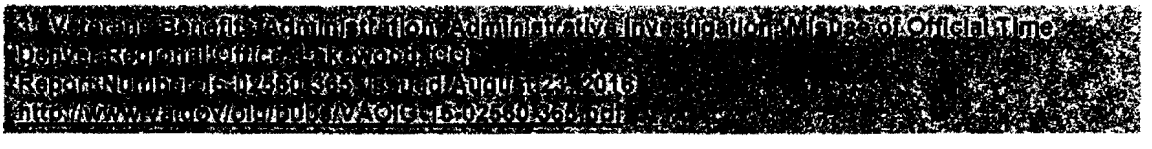
INSTANCES OF SUBSTANTIATED MISCONDUCT BY GS-15 OR ABOVE EMPLOYEES WHERE NO PROSECUTION RESULTED



The OIG Administrative Investigations Division investigated allegations that Ms. Mary Carstensen, former (resigned) Senior Advisor to the VA Secretary, engaged in a conflict of interest resulting in an ethics violation. The evidence substantiated that Ms. Carstensen, maintained a less-than-arm's-length relationship with a Nonprofit Organization (NPO) and violated ethics regulations, as well as her executed Ethics Pledge, to give the NPO greater visibility. She engaged in a conflict of interest when, as a VA employee, she encouraged VA senior leaders to attend NPO-hosted events and provided non-public VA information to them, while receiving over $250,000 in payment from the same NPO over a 3-year period. Ms. Carstensen also failed to fully disclose the income the NPO paid to Good Stewards, LLC on her financial statements and to make full disclosure of her activities to the Office of General Counsel when asking for ethics advice so that they could give her a fully informed ethics opinion based on all available information. The OIG made a criminal referral of the conflict of interest to the U. S. Department of Justice (DOJ) on May 26, 2015. On June 8, 2015, DOJ notified the OIG that they declined to prosecute, although a specific rationale was not indicated. The OIG did not make a recommendation to VA and administratively closed this case, as DOJ declined to prosecute and Ms. Carstensen resigned from her position effective August 4, 2014.



The OIG Administrative Investigations Division investigated an allegation that Mr. Robert Gingell, former (retired) Supervisory Administrative Service Manager, Board of Veterans Appeals (BVA), worked at his privately-owned small business while at the same time being on extended sick leave from BVA. The evidence substantiated that Mr. Gingell engaged in outside employment while on sick leave. Time and attendance records reflected that he was on sick leave more than 22 weeks between January and August 2015. During this time, he was observed on multiple occasions both in person and through social media posts working at his business while on sick leave. The closed the allegation administratively, as Mr. Gingell retired on September 21, 2015, a short time after receiving an OIG administrative subpoena. The OIG did not refer this matter to DOJ.



At the request of the Chairman of the House Committee on Veterans' Affairs , the OIG Administrative Investigations Division investigated allegations that Ms. Melanie Murphy, Director of the Denver VARO, was habitually absent from work during her designated duty hours and submitted incorrect timecards. The evidence substantiated that Ms. Murphy misused her official time when she arrived to her duty station late without taking the appropriate leave; when she was absent without leave; and when she improperly split her workday between her duty station, a non-VA location, and teleworking from home. She also maintained an improper credit hour system for herself and her office staff. The OIG did not substantiate an allegation that she was absent for several weeks at a time without taking sick leave and

administratively closed that allegation. The OIG made four recommendations for corrective action to the Director, Veterans Benefits Administration Continental District. The OIG did not refer this matter to DOJ.

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

OCT 12 2016

The Honorable Bill Nelson
United States Senator
225 East Robinson Street
Suite 410
Orlando, Florida 32801

Dear Senator Nelson:

This is in response to your August 31, 2016 letter on behalf of (b)(6) who alleged that her late husband, (b)(3):38 U.S.C. 5701 did not receive appropriate medical treatment from the Orlando VA Medical Center (VAMC) in Orlando, Florida.

Upon receipt of your letter, OIG clinical staff conducted a review of Ms. Burrell's allegations in conjunction with her husband's VA medical record and determined that further review by the OIG was not warranted at this time.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 16 2016

The Honorable Thomas J. Rooney
Member, United States House
of Representatives
226 Taylor Street, Suite 230
Punta Gorda, Florida 33950

Dear Congressman Rooney:

This is in response to your July 20, 2016 letter on behalf of (b)(6) who filed a complaint with the VA Office of Inspector General (OIG) Hotline concerning a fee allegedly assessed to his cousin, (b)(6) by an individual who assisted her with her application for VA benefits and purportedly offered an "expedited VA application service" in exchange for a fee of one month's benefits totaling $1,113. (b)(6) questioned the legality and integrity of this practice because he alleged the service provided was not expedited and could have been performed free of charge through other avenues.

Our records show that (b)(6) contacted the OIG regarding this matter on three occasions between April and July 2016. Without further evidence of (b)(5) Power of Attorney status for (b)(6) consent to release information relative to her VA claim file to (b)(6) we are precluded by from discussing the details of Ms. Roberts' VA claim file. 38 U.S.C. Section 5701 prohibits, with limited exceptions, the disclosure of any files, records, reports, and other papers and documents pertaining to any VA claim (e.g. medical or benefits) except to the individual to whom the record pertains or the individual's authorized agent or representative.

However, we would like to inform (b)(6) that VA's Office of General Counsel (OGC) is the office responsible for reviewing complaints regarding potentially illegal or unethical behavior by individuals assisting with VA benefits claims. OGC maintains a public website with valuable information regarding this topic, which is available at: http://www.va.gov/ogc/accreditation.asp. Complaints regarding unlawful activities, misconduct, or incompetent representation by a VA-accredited individual may be submitted to:

Department of Veterans Affairs
Office of the General Counsel (022D)
810 Vermont Avenue, NW
Washington, DC 20420

Fax: (202) 273-0197
Email: ogcaccreditationmailbox@va.gov

Alternatively, (b)(6) may wish to contact the State of Florida Department of Elder Affairs at:

Florida Department of Elder Affairs
4040 Esplanade Way
Tallahassee, Florida 32399

Phone: (850) 414-2000
Fax: (850) 414-2004
Email: information@elderaffairs.org
Online: http://elderaffairs.state.fl.us/doea/aps.php

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 29 2016

The Honorable Pete Olson
Member, United States House
of Representatives
6302 West Broadway Street
Suite 220
Pearland, Texas 77581

Dear Congressman Olson:

This is in response to a June 15, 2016 email request from your staff on behalf of (b)(6) concerning his request for an Office of Inspector General (OIG) investigation into his VA disability rating and ongoing claims appeal. We regret the delay in responding.

Our records show that (b)(6) previously contacted the VA OIG Hotline regarding this matter on numerous occasions dating back to 2010. The OIG does not intervene in the determination of veterans' benefits rating decisions or claims processing issues, which is the responsibility of the Veterans Benefits Administration (VBA). Copies of our prior correspondence on this matter are enclosed for your reference.

Upon receipt of your staff's request, our investigations staff conducted an additional review of (b)(6) allegations; however, they saw no grounds to warrant an OIG investigation. We note from the documentation forwarded to the OIG that (b)(6) is addressing these matters through the appropriate channels within VBA and the Board of Veterans Appeals, and we encourage (b)(6) to continue working with these offices to determine if additional compensation is appropriate. Lastly, VA records indicate a Statement of the Case (SOC) was issued to (b)(6) on July 19, 2016. If he has not received a copy of the SOC to date, he may wish to follow up with his local VA Regional Office for assistance.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

MICHAEL J. MISSAL

Enclosures

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
P.O. BOX 50410
WASHINGTON, DC 20091-0410
Telephone: 800-488-8244 (Toll Free)
FAX: 202-565-7936
e-mail: vaoighotline@va.gov

In Reply Refer to: 53E/99 / 2016-19402

Dear Correspondent:

This is in response to the correspondence you sent to the VA's Office of Inspector General (OIG) Hotline. The Office of Inspector General limits investigative efforts to those issues that represent the most serious potential risk to VA or for which OIG may be the only avenue of redress. There are avenues available to you that can better address your concerns. We have marked the box below as a suggestion for a possible next step. **We plan to take no further action, nor will we respond to future submissions on those issues where we have provided you with an alternate avenue of redress.**

✓ (B1) **Claim Processing** – We cannot change, reverse, or speed up decisions made on individual benefits claims by Veterans Benefits Administration officials. We cannot contest issues for you, resolve your disagreement regarding the evidence considered or overturn VA benefit decisions you received. Decisions on individual benefits claims are the responsibility of the Veterans Benefits Administration through VA regional offices across the country. You may reach a VBA Call Center by calling **800-827-1000** (toll free).

☐ (B2) **Appeals** – The processing of claims for VA benefits is the subject of an extensive system of checks and balances, including appeals to the Board of Veterans' Appeals (BVA) and to the Court of Appeals for Veteran Claims. Because of this process, OIG does not get involved in complaints related to individual claims. If you have not already done so, you may reach a VBA Call Center at **800-827-1000** (Toll free) to ask a benefits counselor to explain your appeal rights. If your appeal is currently with BVA and you wish to learn the status, you may call the Veterans Information Office at **202-565-5436**.

✓ (B3) **Under Secretary for Veterans Benefits** – You may wish to bring your concerns to the attention of the Under Secretary for Veterans Benefits. You may direct your letter to **Under Secretary for Veterans Benefits Administration (20), 810 Vermont Avenue, NW, Washington, DC 20420**. You may also call the **VBA Office of Communications and Case Management at 202-273-5674** or **202-273-7453**.

☐ (B4) **Benefits Checks** – To report a change of address or to request a replacement for a lost or stolen check, call your local regional office toll free at **800-827-1000**.

(B5) **Educational Benefits** – For issues related to your VA educational benefits you may contact your regional educational center toll free at **888-442-4551**, or **www.gibill.va.gov**. If you have already done so and continue to experience problems, you may contact **202-461-9800** to discuss your concerns.

☐ (B6) **Vocational Rehabilitation** – For questions or concerns related to your Vocational Rehabilitation benefits, call your local regional office toll free at **800-827-1000**.

☐ (B7) **Home Loan Guaranty** – To obtain a Certificate of Eligibility for a VA- guaranteed mortgage or discuss concerns related to your existing home loan, you may contact a loan processing center in your region by calling _____.

☐ (B8) **Loan Guaranty Service** – You may wish to direct your concerns in writing to **Loan Guaranty Service (26), 810 Vermont Avenue, NW, Washington, DC 20420**.

☐ (B9) **Fiduciary/Guardianship Program** – To report your concerns with the day-to-day management of your funds or your guardian's decisions as to how to disburse funds on your behalf, you may contact the Guardianship Unit at your local regional office by calling **800-827-1000** toll free.

☐ (B10) **Apportionment** – If you believe that your spouse is not adequately meeting his/her fiduciary responsibilities, you may be eligible to receive an apportionment of VA benefits. To obtain additional information on eligibility and how to submit a claim, you may contact your local regional office toll free at **800-827-1000**.

☐ (B11) **Debt Management Center** – To discuss issues related to a VA debt, including how you incurred the debt and the status of your repayment, contact the VA Debt Management Center toll free at **800-827-0648**.

☐ (B12) **Life Insurance** – For information on VA Life Insurance programs, contact the Philadelphia Insurance Center toll free at **800-669-8477**.

You may also wish to contact the Patient Advocate at 713-794-7884 to address concerns regarding your post-surgery examination.

Sincerely,

(b)(6)

8/13/16

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

OCT 26 2010

The Honorable Kay Bailey Hutchison
United States Senator
145 Duncan Drive, Suite 120
San Antonio, Texas 78226

Dear Senator Hutchison:

This is in response to your August 26, 2010, letter on behalf of Mr. Ronald Bennett, who requested the Office of Inspector General (OIG) investigate the handling of his VA claim for benefits. We received your letter from the VA Regional Office in Houston on September 14, 2010.

(b)(6) did contact the OIG Hotline on June 22, 2010 with similar allegations. On August 13, 2010, he was advised by mail that the OIG does not get involved in claims decisions or claims processing issues and that he should contact the Office of Communications and Case Management within the Office of the Under Secretary for Benefits on this matter. He was also provided contact information.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

for GEORGE J. OPFER

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
PO Box 50410
Washington DC 20091–0410

In Reply Refer To: 53E/99/2011-4635

January 10, 2011

(b)(6)

Dear (b)(6)

This letter is in response to a letter you forwarded to President Barack Obama concerning your claim for disability compensation that was forwarded to the Houston VA Regional Office for response. Because your letter to the President mentioned concerns regarding the Department of Veterans Affairs (VA) Office of Inspector General (OIG), the Houston Regional Office requested that we respond to those concerns.

As you were informed in our previous correspondence, VA OIG cannot change, reverse, or speed up decisions made on individual benefits claims by Veterans Benefits Administration officials. We cannot contest issues, resolve disagreements regarding the evidence considered, or overturn VA benefits decisions. Decisions on individual benefits claims are the responsibility of the Veterans Benefits Administration through VA regional offices across the country. You may reach a VBA Call Center by calling **800-827-1000** (toll free).

The processing of claims for VA benefits is the subject of an extensive system of checks and balances, including appeals to the Board of Veterans' Appeals (BVA) and to the Court of Appeals for Veteran Claims. Because of this process, OIG does not get involved in complaints related to individual claims.

The Office of Inspector General limits investigative efforts to those issues that represent the most serious potential risk to VA or for which OIG may be the only avenue of redress.

Sincerely,

(b)(6)