(March 4, 2016)

In order to further improve the lines of communication and to respond to the concerns between the National VA Council and you our members, I have established a National VA Council Briefing. This NVAC Briefing will bring you the latest news and developments within DVA and provide you with the current status of issues this Council is currently addressing. I believe that this NVAC Briefing will greatly enhance the way in which we communicate and the way in which we share new information, keeping you better informed.

Alma L. Lee
National VA Council, President

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In This Briefing: Administrative Summaries of Investigation Regarding Wait Times - Louisiana

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The Department of Veterans Affairs, Office of Inspector General (OIG), conducted extensive work related to allegations of wait time manipulation after the allegations at the Phoenix VA Health Care System in April 2014. Since that event and through fiscal year 2015, we have received numerous allegations related to wait time manipulation at VA facilities nationwide from veterans, VA employees, and Members of Congress that were investigated by OIG criminal investigators.

As we stated at Congressional hearings, at this time the OIG has completed 77 criminal investigations related to wait times and provided information to VA's Office of Accountability Review for appropriate action. It has always been our intention to release information regarding the findings of these investigations at a time when doing so would not impede any planned prosecutive or administrative action. OIG will begin a rolling publication of these administrative summaries of investigation by state so that veterans and Congress have a complete picture of the work completed in their state. As other reviews are completed, we intend to post them to our website.

You may view and download these administrative summaries of investigation by clicking on the link to our webpage at **www.va.gov/oig/publications/administrative-summaries-of-investigation.asp** and selecting the appropriate state. The individual summaries may also be accessed by selecting the weblinks below.

VA OIG Administrative Summary of Investigation at the New Orleans/Baton Rouge VA Medical Center (14-02890-168)

VA OIG Administrative Summary of Investigation at the Shreveport VA Medical Center (14-02890-173)

> ***Note:*** At the request of Senator Richard Burr, then-Ranking Member of the Senate Committee on Veterans' Affairs, the OIG Office of Healthcare Inspections (OHI) also conducted a separate inspection at the Overton Brooks VA Medical Center, Shreveport, Louisiana, to address allegations concerning patient care deficiencies and the availability of mental health therapy. The inspection results were published on January 7, 2016, *Healthcare Inspection: Patient Care Deficiencies and Mental Health Therapy Availability, Overton Brooks VA Medical Center, Shreveport, Louisiana*, Report No. 14-05075-447.

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