Department of Veterans Affairs
Office of Inspector General
December 2016 Highlights

OIG REPORTS

Review of Antimicrobial Stewardship Programs in Veterans Health Administration Facilities

As directed by the Senate Appropriations Committee report to accompany H.R. 2029, Military Construction, Department of Veterans Affairs, and Related Agencies Appropriation Bill 2016, and at the request of Senator Dianne Feinstein, the Office of Inspector General (OIG) reviewed Veterans Health Administration (VHA) implementation of Antimicrobial Stewardship Programs (ASPs). The majority of VHA facilities had established ASPs; however, OIG identified variations with program implementation. A large majority of facilities had written policies and designated ASP champions; however, over one third did not timely complete program evaluation, and facilities reported less than 50 percent compliance with staff education on appropriate use of antibiotics. VHA made efforts to collect and analyze data on antibiotic use and resistance but did not endorse one standard data collection tool for inter-facility comparisons and consistency of data collection and reporting. Additionally, facilities did not consistently generate clinical outcome reports on antibiotic usage. Therefore, VHA cannot effectively measure positive or negative national trends on antibiotic use to guide improvement efforts. With standardization, individual facility and system-wide trends can be analyzed. Further, in order to achieve optimal ASPs, facility leaders need to provide dedicated staff, administrative support, and essential tools to develop and maintain such programs. OIG recommended that the Under Secretary for Health implement procedures to ensure that facilities comply with VHA Directive 1031 requirements, including the completion of annual evaluations, designation of provider and pharmacy champions, staff education, and the provision of adequate dedicated staffing and resources; require VHA facilities to track and generate clinical outcome reports on antibiotic use; and consider implementing standardized tools and definitions for antimicrobial stewardship data and a uniform reporting system to permit analysis of comparable information over time. [Click here to access report.]

Review of Complaints Regarding Mental Health Services Clinical and Administrative Processes, VA St. Louis Health Care System, St. Louis, Missouri

OIG conducted an inspection pursuant to a June 2014 request from Senator Bernie Sanders, then Chairman of the Senate Veterans Affairs Committee, to assess allegations regarding deficiencies in Mental Health (MH) services clinical processes including productivity, data reporting, access, quality of assessments and care, and administrative processes at the VA St. Louis Health Care System (HCS), St. Louis, Missouri. Of 19 allegations, 6 were substantiated while 13 were not substantiated. OIG also identified 8 additional findings. OIG found that outpatient psychiatrists had fewer-than-expected appointment slots and encounters in fiscal year (FY) 2013; outpatient psychiatrists' productivity data were inconsistent with the number of daily encounters; some outpatient psychiatrists' coding error rates exceeded VHA's minimum accuracy standards for the period May through August 2013 and VHA-required

follow-up was not completed; inadequate consult management of ancillary group treatment referrals for two patients; outpatient MH and post-traumatic stress disorder (PTSD) clinics treatment delays averaged 3 days in FY 2013; an MH clinic nurse did not adequately assess an unscheduled patient's treatment needs; a former staff member did not provide timely military sexual trauma treatment or follow-up; outpatient PTSD staff failed to provide timely care to a walk-in patient or include a second patient in treatment planning involving transfer to the MH clinic; the "public" facsimile machine used for Veterans Benefits Administration, Vocational Rehabilitation and Employment referrals was not reliable or attended to properly; two Compensation & Pension evaluators entered erroneous information in a veteran's electronic health record; and the facility management insufficiently investigated two of three MH patient deaths. [Click here to access report.]

Review of Alleged Wasted Funds at Consolidated Patient Account Centers for Windows Enterprise Licenses

In November 2015, OIG received an allegation that employees at the Consolidated Patient Account Centers (CPACs) were required to use two Windows enterprise licenses when thin clients were converted to computers. According to the complaint, CPACs operated within a virtual desktop infrastructure environment that required CPAC employees to log onto a virtual machine that had its own Windows enterprise license to perform their work-related functions. Allegedly, employees were using computers that required Windows enterprise licenses only as a gateway to access a virtual machine that also required a license. The complaint further alleged that the Windows enterprise licenses on the computers were not necessary because the computers were being underutilized. OIG substantiated the allegation that VA Office of Information and Technology (OIT) wasted VA funds at CPACs to purchase underutilized computers that also required Windows enterprise licenses to operate. Specifically, CPAC employees used these computers only as gateways to access virtual machines on the network server that had individual Windows enterprise licenses. This occurred because OIT mandated that CPACs replace thin clients which depend on networked resources to operate with computers. However, OIT did not consider the CPACs' operating framework before purchasing the computers or mandating the replacement. Because CPACs did not change their operating framework when they converted from thin clients and only used computers as gateways, OIT paid for underutilized computers and avoidable licenses. As a result, OIT wasted approximately $7.2 million in VA funds converting CPACs from thin clients to computers. OIG recommended the Assistant Secretary for OIT implement policies and procedures to ensure cost effective utilization of information technology equipment, installed software, and services, and ensure the coordination of acquisitions with affected VA organizations. This will help ensure VA's operating framework and organizational needs are considered prior to acquisitions. The Assistant Secretary for OIT concurred with the OIG recommendation and provided plans for the corrective action. OIG will monitor the planned actions and follow up on their implementation. [Click here to access report.]

Review of Alleged Misuse of VA Funds at the VA Pittsburgh Healthcare System
OIG substantiated an allegation that VA Pittsburgh Healthcare System (VAPHS) staff provided free meals for medical residents without the required meal plan. The VAPHS Director could have authorized the meals under an approved meal plan for residents comparable to those at the facility's index hospital, the University of Pittsburgh Medical Center. However, the Chief of Staff, who is responsible for reviewing this activity annually, overlooked the requirement for an approved meal plan. As a result, the VAPHS used approximately $441,000 in appropriated funds to purchase catered meals for medical residents from April 2013 through March 2015 without such a plan. In addition, OIG did not substantiate the assertion that the meals were lavish, but the cost of these commercial meals was more than the cost of similar catered meals potentially available from the Veterans Canteen Service (VCS). The VAPHS missed the opportunity to acquire potentially less expensive meals from VCS, rather than using this competitively selected commercial caterer. In January 2016, in response to OIG's review, the VAPHS Director established a meal plan for residents.
[Click here to access report.]

Review of Alleged Improper Non-VA Community Care Consult Practices at Ralph H. Johnson VA Medical Center, Charleston, South Carolina
On April 14, 2015, the Office of Special Counsel forwarded to the VA Secretary allegations of wrongdoing that occurred at the Ralph H. Johnson VA Medical Center (VAMC) in Charleston, SC, in early FY 2014. A multidisciplinary team of auditors and health care inspectors began to address the allegations. These allegations were that management at the VAMC directed claims assistants to discontinue pending consult requests that were "aged out," a phrase previously unfamiliar to the complainants; Fee Basis clerks were directed to discontinue consults by marking them as completed when they were incomplete; and management interfered in the consult request process, including directing care for ineligible patients and allowing the Fee Basis Unit chief to direct his own care. OIG partially substantiated the allegation that management directed claims assistants to discontinue consults, but found that practice to be consistent with the VAMC's administrative policy. OIG substantiated the allegation that the Fee Basis clerks did not properly discontinue consults; identifying three that had been marked completed prior to medical documentation being uploaded into the patient's electronic health record. OIG did not substantiate the allegation that management directed care for ineligible patients and allowed the Fee Basis Unit chief to direct his own care. OIG recommended the VAMC Director initiate an independent review regarding one patient that experienced a delay in receiving specialty care and that the Director ensures that consults that were not acted on within seven days can be tracked and managed in accordance with national policy. The VAMC Director subsequently had the one patient's case reviewed by three outside experts who determined that the delay did not change the outcome for the patient.
[Click here to access report.]

CRIMINAL INVESTIGATIONS

Former Sacramento, California, VAMC Chief of Podiatry and Vendor Indicted for Fraud

The former chief of podiatry for the Sacramento, CA, VAMC and a long time VA vendor were both indicted for health care fraud, conspiracy to violate the anti-kickback statute, and conspiracy to commit wire fraud. The vendor held local and national contracts to supply prosthetic and orthotic devices to VA. OIG, VA Police Service, and Homeland Security Investigations investigated allegations that the chief willfully wrote consults for substandard orthotic footwear provided to veterans. The vendor then billed VA for the substandard footwear at inflated rates and paid the chief's spouse $60,000 for patient referrals. In addition, the defendants conspired to falsely claim to VA where the vendor's products were manufactured. VA was informed that the vendor's products were domestically produced when they were actually made in China. These false statements subsequently helped the vendor land lucrative Government contracts. A senior employee working for the vendor recently pled guilty to Conspiracy to Commit Wire Fraud. The loss to VA is approximately $2 million.

Veteran Sentenced for Surety Bond Fraud

A veteran was sentenced to 150 months' incarceration, 3 years' supervised release, and was ordered to pay $4.1 million in restitution. A multi-agency investigation revealed an extensive surety bond fraud scheme that affected multiple Federal agencies and over $935 million in Government construction contracts. The defendant, along with other co-conspirators, used Government-owned lands or bogus trusts as assets to back bid, payment, and performance bonds while accepting approximately $10 million in bonding fees. The impacted VA contracts totaled over $97 million, including some *American Recovery and Reinvestment* funds.

Six former Insys Therapeutics, Inc., Pharmaceutical Executives and Managers Arrested for Bribery and Defrauding Health Insurers

As the result of a multi-agency investigation, six pharmaceutical executives and managers, formerly employed by Insys Therapeutics, Inc., were indicted and arrested on charges that they allegedly led a nationwide conspiracy to bribe medical practitioners to unnecessarily prescribe a fentanyl-based pain medication and defraud health care insurers. The medication, called "Subsys," is a powerful narcotic intended to treat cancer patients suffering intense episodes of breakthrough pain. In exchange for bribes and kickbacks, the practitioners allegedly wrote large numbers of prescriptions for the patients, most of who were not diagnosed with cancer. The indictment also alleges that the defendants conspired to mislead and defraud health insurance providers who were reluctant to approve payment for the drug when it was prescribed for non-cancer patients. VA's Civilian Health and Medical Program paid the company approximately $3.3 million for Subsys.

Salt Lake City, Utah, VAMC Associate Chief of Pharmacy Charged with Drug Diversion

A Salt Lake City, UT, VAMC associate chief of pharmacy was charged with acquiring possession of a controlled substance by fraud, forgery, deception, and subterfuge. An

OIG investigation resulted in the defendant being charged with diverting approximately 25,000 pills of oxycodone, hydromorphone, Adderall, buprenorphine, Ritalin, and tramadol from the inpatient pharmacy from October 2011 to March 2015.

Palo Alto, California, HCS VA Physician Charged With Prescription Fraud
A physician working for the VA Palo Alto HCS was charged with prescription fraud after admitting to diverting oxycodone tablets from his patients. For over 2 months, the physician prescribed oxycodone tablets to multiple patients that had no need for this medication. The physician then explained to these patients that he had made a mistake and retrieved the tablets either directly from the patient or by making arrangements to recover them from United Parcel Service during the shipping process. The defendant claimed that a dependence on pain medication had led him to divert the oxycodone tablets. The doctor was terminated from VA employment.

Former St. Joseph, Missouri, Community Based Outpatient Clinic Employee Pleads Guilty to Drug Diversion
A former St. Joseph, MO, Community Based Outpatient Clinic (CBOC) employee received a suspended imposition of sentence and was placed on 3 years' probation after pleading guilty to fraudulently attempting to obtain a controlled substance. An OIG and local police investigation resulted in the defendant being charged after he wrote VA prescriptions for a non-veteran. The physician wrote the fraudulent prescriptions from August 2015 to April 2016 in order to obtain the controlled substances for his personal use.

Former St. Louis, Missouri, VAMC Employee Pleads Guilty to Conspiracy to Steal Government Funds
A former St. Louis, MO, VAMC employee pled guilty to conspiracy to steal Government funds. A VA OIG and Federal Deposit Insurance Company OIG investigation revealed that, from October 2012 to February 2014, the defendant was an outside contractor and received purchase orders from the medical center for maintenance work totaling $144,629. During this time, the defendant allegedly kicked back payments of approximately $41,250 to a VA official. The defendant later became a VA employee and arranged for his unqualified stepson to receive purchase orders for maintenance work. From April 2014 to April 2015, the defendant's stepson received $125,549 for maintenance work. During this time, the stepson allegedly kicked back payments of approximately $39,000 to the same VA official and approximately $20,800 to the defendant. This investigation is ongoing and there is an anticipated loss of $451,853.

Veteran Sentenced for Travel Benefit Fraud
A veteran was sentenced to 3 years' probation and was ordered to pay $19,079 in restitution after pleading guilty to grand larceny relating to beneficiary travel fraud. A VA OIG, New York State Medicaid OIG, and NY District Attorney's Office investigation revealed that on 747 occasions the defendant claimed and received Medicaid-paid transportation to and from the Montrose, NY, VAMC while also being reimbursed for travel by VA. The loss to VA was $19,079.

Fiduciary Pleads Guilty to Theft of Government Funds
The sister of a veteran pled guilty to theft of Government funds. An OIG investigation revealed that the defendant assumed responsibility for more than $148,000 of her brother's funds at the time she was appointed his fiduciary. The defendant then failed to provide her required annual accounting and ignored repeated attempts by VA to contact her. By the time the defendant was replaced by a professional fiduciary, more than $100,000 in additional VA funds had been deposited. The defendant allegedly used more than $95,000 of the VA funds to pay off her personal loans and to purchase a new BMW vehicle.

Muskogee, Oklahoma, VA Regional Office Employee Sentenced for Theft of Government Funds
A Muskogee, OK, VA Regional Office employee was sentenced to 5 years' probation and was ordered to pay $39,606 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant used his position in the education benefits office to send funds, using the accounts of two separate veterans, to a Green Dot debit card account he opened in his brother's name.

Former Mind Spa Inc., Employee Sentenced for Workers' Compensation Program Fraud
A former employee of Mind Spa Inc., was sentenced to 18 months' incarceration and 2 years' supervised release. Twenty-eight defendants, to include Office of Workers' Compensation Programs (OWCP) claimants, former United States Postal Service (USPS) and VA employees, doctors, medical provider employees, a Department of Labor (DOL) Claims Examiner, and a claims representative were charged with various crimes related to their roles in a health care fraud scheme. A VA OIG, USPS OIG, DOL OIG, Internal Revenue Service (IRS) Criminal Investigation Division (CID), Treasury Inspector General for Tax Administration, and Social Security Administration OIG investigation revealed that the defendants' actions caused more than $9.5 million to be fraudulently billed to the DOL OWCP.

Friend of Deceased VA Beneficiary Sentenced for Theft of Government Funds
The friend of a deceased VA beneficiary was sentenced to 21 months' incarceration, 2 years' supervised release, and was ordered to pay $396,057 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were issued after the beneficiary's death in September 2005.

Daughter of Deceased VA Beneficiary Given Pretrial Diversion
The daughter of a deceased VA beneficiary entered a pretrial diversion program after an OIG investigation revealed that she stole VA funds that were direct deposited after her mother's death in November 2003. The defendant subsequently reimbursed VA and a local bank the entire outstanding overpayment of $166,289 as part of the program requirements.

Grandson of Deceased VA Beneficiary Indicted for Theft of Government Funds
The grandson of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited into a joint account after the veteran's death in May 2008. The loss to VA is $143,106.

Friend of Deceased Beneficiary Found Guilty of Theft of Government Funds
A friend of a deceased beneficiary was found guilty at trial of theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited into a joint account after the beneficiary's death in February 2008. The loss to VA is $100,610.

Daughter of Deceased VA Beneficiary Indicted for Theft of Government Funds
The daughter of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited after her mother's death in December 2009. The defendant is also alleged to have submitted falsified documents to VA on several occasions after her mother's death in order to continue receiving the VA benefit payments. The defendant allegedly changed mailing addresses and bank accounts multiple times in order to avoid detection. The loss to VA is $99,006.

Two Non-Veteran Corporate Officers Charged with Service-Disabled Veteran-Owned Small Business Fraud
Two non-veteran corporate officers of a Service-Disabled Veteran-Owned Small Business (SDVOSB) were indicted for conspiracy to defraud the United States, major fraud against the United States, and wire fraud. One of the corporate officers was also indicted for false statements. A multi-agency investigation resulted in the defendants being charged with recruiting a veteran and establishing a "pass-through" SDVOSB for the purpose of obtaining Federal construction contracts for their legitimate businesses. The company, which falsely self-certified the "pass-through" as an SDVOSB, was awarded almost $16 million in Federal contracts between 2008 and 2014, of which over $12 million were VA contracts.

Beauty School Owners Plead Guilty to Fraud
The owner of a beauty school pled guilty to conspiracy to commit wire fraud and engaging in monetary transactions in property derived from specified unlawful activity. A second owner pled guilty to conspiracy to commit wire fraud. An OIG, IRS CID, and Naval Criminal Investigative Service investigation determined that the owners of the school provided false information to VA concerning the number of hours of instruction and the manner and quality of the instruction provided to the enrolled veterans whose tuition was paid by VA. In reality, the enrolled veterans rarely, if ever, received instruction from employees at the school. The owners required the enrolled veterans to sign in and out at the school each day in order to create the appearance that they were attending the required number of hours, but permitted the students to leave the school during the hours they were ostensibly attending class. As a result, VA paid over

$4.5 million to the school in tuition funds and over $10.5 million to students to cover housing costs and other educational expenses.

VA Loan Guaranty Program Beneficiary Sentenced for False Statement
A VA loan guaranty program beneficiary was sentenced to 27 months' incarceration, 60 months' supervised release, and was ordered to pay $107,000 in restitution after pleading guilty to making a false statement to obtain a loan. A VA OIG, United States Postal Inspection Service (USPIS), Social Security Administration OIG, and local police investigation resulted in the defendant being charged with using allegedly falsified information (including employment and income information) to obtain a $423,000 home loan guaranteed by VA, and then subsequently defaulting on the loan. The defendant was also alleged to have provided false information to obtain multiple vehicle loans, and then manufactured a scheme to remove the first liens from the vehicle titles in order to resell the vehicles to legitimate dealers.

Former Des Moines, Iowa, VAMC Employee Sentenced for Possession of Child Pornography
A former Des Moines, IA, VAMC employee was sentenced to 135 months' incarceration and 15 years' supervised release after pleading guilty to possession of child pornography. An OIG and Homeland Security Investigations investigation revealed that while the defendant was working at the medical center he searched for child pornography using a shared VA computer.

Former Sales Representative Sentenced for Purchase Card Fraud
A former sales representative for a VA vendor was sentenced to 25 months' incarceration, 3 years' supervised release, 100 hours' community service, and was ordered to pay $1,141 in restitution and a $600 special assessment. An OIG investigation revealed that the defendant used her position to gain access to multiple VA purchase card numbers and then used the cards to fraudulently purchased tickets to sporting events.

Majority Owner of the New England Compounding Center Sentenced for Structuring Withdrawals
The majority owner of the New England Compounding Center (NECC) was sentenced to 1 year of probation and was ordered to forfeit $4,600. The defendant's husband was sentenced to 2 years' probation and was ordered to forfeit $119,647. Both defendants were also ordered to pay criminal fines totaling $59,600. The defendants previously pled guilty to making structured withdrawals totaling approximately $124,000 following the initiation of an OIG, Federal Bureau of Investigation (FBI), Food and Drug Administration Office of Criminal Investigations, USPIS, and Defense Criminal Investigative Service investigation that ultimately determined that NECC products caused the deaths of 64 people and caused fungal infections in approximately 700 others. Although no known VA patients died or became ill as a result of receiving an NECC product, VA did purchase approximately $516,000 of NECC products that were allegedly produced in unsanitary conditions and in an unsafe manner. Neither defendant had an active role in the operations or management of NECC.

Non-Veteran Sentenced for Theft of VA Property
A non-veteran was sentenced to 3 years' probation after pleading guilty to unlawful conversion of Government property. An OIG and VA Police Service investigation revealed that the defendant assisted in selling VA-owned property stolen from the Manchester, NH, VAMC, via eBay. The defendant's co-conspirator stole over $10,000 worth of tools and equipment and over $300 worth of scrap metal from the medical center. Many of the stolen items were subsequently recovered.

Former VA CBOC Contract Employee Sentenced for Assault
A former VA CBOC contract employee was sentenced to 24 months' probation and ordered to participate in a mental health treatment program after pleading guilty to assault. An OIG investigation revealed that the defendant was terminated from the CBOC pursuant to an inappropriate relationship with one of his female veteran patients. After his termination, the employee returned to the CBOC and made threatening statements. The following day, the employee came back to the facility armed with a handgun and paraded outside the front of the building.

Veteran Sentenced for Communicating Threats
A veteran was sentenced to 4 months' incarceration, 1 year of supervised probation, and was ordered to attend mental health and substance abuse counseling for communicating threats. The defendant originally had been given the opportunity to enter into a pretrial diversion agreement with the U.S. Attorney's Office; however, he failed to follow the conditions of the agreement. An OIG investigation revealed that in June 2013 the defendant made threats to use an explosive device and a firearm to kill VA employees and his VA fiduciary.

Veteran Enters into Pretrial Agreement after Making Threats
A veteran entered into a pretrial agreement after being charged with making threats. The pretrial agreement places the defendant on 18 months' supervised probation. An OIG investigation revealed that the veteran made a direct threat to kill a VA employee at the Fayetteville, AR, VAMC. After a 10-month mental evaluation, the defendant was determined to be competent.

Fugitives Arrested with OIG Assistance
A veteran was arrested by the New York Police Department Warrant Squad with the assistance of OIG; the FBI; Boise, ID, Police; and the VA Police Service at the New York, NY, VAMC. The veteran was wanted for the kidnapping, rape, and homicide of an 18-year-old woman in Boise, Idaho. A second veteran was arrested by the United States Marshals Service with the assistance of OIG at the Vet Center in South Burlington, Vermont. The veteran was wanted for charges of child pornography.

ADMINISTRATIVE SUMMARIES OF INVESTIGATION
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 FY 2015, OIG 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.

At this time, OIG has completed more than 90 criminal investigations related to wait times and provided information to VA's Office of Accountability Review for appropriate action. As other administrative summaries of investigation are completed, OIG intends to post them to our website so that veterans and Congress have a complete picture of the work conducted in their state.

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.

Administrative Summaries of Investigation (December 2016)	
Summary Number	**Location**
14-02967-83	Los Angeles, California, VAMC
14-02890-87	Phoenix, Arizona, VAMC
14-02890-88	Loma Linda, California, VAMC
14-02890-122	Charleston, South Carolina, VAMC
14-02890-404	Columbia, South Carolina, VAMC
14-02890-406	Tampa, Florida, VAMC
14-02890-407	Dallas, Texas, VAMC
14-02890-408	Fort Harrison, Montana, VAMC
14-02890-410	Las Vegas, Nevada, VAMC
14-02890-411	Temple, Texas, VAMC
14-02890-416	Canton, Ohio, CBOC

ADMINISTRATIVE INVESTIGATION ADVISORIES

OIG independently reviews allegations and conducts administrative investigations generally concerning high-ranking senior officials and other high profile matters of interest to Congress and the Department. While these reviews and investigations may result in the issuance of a formal report, they may also lead to the issuance of an administrative advisory to VA senior leadership. Administrative advisories are issued if

allegations are substantiated but no recommendations are made or are unsubstantiated during the course of the investigation and there is a need to notify VA leadership of the investigative results.

A major component of OIG's vision is an unwavering commitment to being a transparent organization. In keeping with this vision, OIG is maintaining transparency with veterans, Congress, and the public by releasing administrative investigation advisories issued by OIG. As other administrative investigation advisories are completed, they will be available on our website if they are not prohibited from public disclosure.

You may view and download these administrative investigation advisories and closure memoranda by clicking on the links below on our webpage.

http://www.va.gov/oig/publications/administrative-investigation-advisories.asp

Administrative Investigation Advisory (December 2016)	
Advisory Number	**Title**
15-01879-109	Administrative Investigation – Alleged Conflict of Interest, Veterans Benefits Administration, Office of Economic Opportunity, Washington, DC

MICHAEL J. MISSAL
Inspector General