

**Memorandum to the File
Case Closure**

**Alleged Misuse of Position
Greater Los Angeles Healthcare System, California
(2014-01144-IQ-0003)**

The VA Office of Inspector General (OIG) Administrative Investigations Division investigated an allegation that Dr. (b) (7) (C), Greater Los Angeles Healthcare System (GLAHS), diverted VA patients to her private practice at the (b) (7) (C). To assess this allegation, we reviewed all (b) (7) (C) billing records sent to GLAHS, interviewed Dr. (b) (7) (C) and interviewed the veteran patient who Dr. (b) (7) (C) allegedly diverted. We also reviewed personnel and email records, applicable Federal laws and regulations, and VA policy.

VA OIG Hotline received an anonymous complaint alleging that Dr. (b) (7) (C) diverted VA patients to her private practice. The complainant stated that an identified veteran patient said that he would not return to GLAHS, because he could get an appointment more quickly at Dr. (b) (7) (C) private practice.

The Standards of Ethical Conduct for Employees of the Executive Branch require employees to act impartially and not give preferential treatment to any private organization, and to avoid any actions creating the appearance that they are violating the law or ethical standards. 5 CFR §2635.101(b)(8) and (14). It further states that employees shall not use their public office for their own private gain or for the private gain of friends, relatives, or persons with whom the employee is affiliated in a nongovernmental capacity. Id., at .702.

Dr. (b) (7) (C) told us that she began her VA employment in (b) (7) (C) initially as the (b) (7) (C) at GLAHS in (b) (7) (C). She said that in the past, she worked as much as 30 hours a week but that she now works only 10 hours each week at VA. In addition to working at GLAHS, she also began working at (b) (7) (C) in (b) (7) (C) and that when the previous (b) (7) (C) owner retired in (b) (7) (C) she purchased the private practice, assuming her current role as the executive of the business.

The identified veteran patient, who was recently examined by Dr. (b) (7) (C) at GLAHS, told us that there was about a 4-month wait between an eye exam and getting a glass fitting appointment at GLAHS. He said through speaking with other veteran patients, he learned that he could go to a variety of nearby facilities, one of which was (b) (7) (C) but the veteran patient said that no VA employee ever told him of Dr. (b) (7) (C) private practice. He said that although it could take several weeks to get glasses through VA, he was appreciative of the staff and the hard work they did and that he accepted the waiting period as part of going to VA.

Email records we reviewed contained no evidence of Dr. (b) (7)(C) diverting veteran patients to her private practice. Further, (b) (7)(C) billing records reflected that, since (b) (7)(C) when Dr. (b) (7)(C) began working for VA, (b) (7)(C) sent no bills to GLAHS for medical services provided to VA veteran patients. Moreover, we confirmed that the identified veteran patient was never referred to or treated by (b) (7)(C).

Dr. (b) (7)(C) told us that GLAHS had significant problems with the process of getting eyeglasses to veterans, resulting in wait times of up to 4 months. She said that resulted in veteran patients, at times, becoming angry and verbally abusive toward GLAHS staff. We found that the medical center addressed this eyeglass wait time issue by awarding contract VA262-14-Q-1212 to Ferris Optical, a California based supplier, on January 7, 2014. In a February 10, 2014, email, Mr. (b) (7)(C), VISN 22 (b) (7)(C), told us that the new contract served as a backup to the agreement the VISN currently had with another contractor, VA Boise Optical Lab, to address the delays in getting eyeglasses to veterans in a timely manner. This backup agreement allowed medical center staff to utilize this second contractor supplier when the primary supplier could not meet the needs of the veterans in a timely manner.

Conclusion

We did not substantiate that Dr. (b) (7)(C) misused her position by directing veteran patients to her private practice. The one identified veteran patient told us that other veterans told him, and not any VA staff, of the option to use non-VA services to obtain eyeglasses. Further, we found no email records reflecting Dr. (b) (7)(C) referred patients to her private practice, and (b) (7)(C) billing records reflected no invoices sent to VA for medical services. Moreover, (b) (7)(C) records contained no information reflecting that (b) (7)(C) provided medical services to the identified veteran patient.

During the course of our investigation, we found that it took up to 4 months for GLAHS to get eyeglasses to veterans and that these lengthy wait times upset some veteran patients, resulting in their anger and being verbally abusive. We found that GLAHS addressed this issue with a second contract in an attempt to reduce the wait times for eyeglasses. However, the contract was so new that we were unable to determine whether the wait times decreased as a result of the contract.

This allegation is being closed without issuing a formal report or memorandum.

Prepared by: _____

(b) (7)(C)

2/18/2014

Date

Approved: _____

2/18/14

Date