Administrative Closure

Oversight Review of Facility Response to an Internal Investigation's Findings and Recommendations
VA Northern Indiana Health Care System
Marion, IN
MCI# 2014-01311-HI-0479

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an oversight review of the VA Northern Indiana Health Care System (NIHCS) response to allegations made by an NIHCS staff. The staff alleged an urgent care provider habitually refused to see patients and initiated inappropriate conversations, and the facility had not taken appropriate action because there was a shortage of physicians.

Background: NIHCS, part of Veterans Integrated Service Network (VISN) 11, consists of two campuses located in Fort Wayne and Marion, IN. The Marion campus provides, among other services, an urgent care clinic.

The OIG Hotline Division received the complaint on December 7, 2013, and referred it to OHI on December 13. On December 27, the OHI Hotline Working Group (HWG) discussed the complaint and elected to refer the case to VISN 11 with a response request. On January 15, 2014, the OIG Hotline Division sent the request to VISN 11 and received their response on February 21. On April 8, the HWG determined the response was inadequate and opened a hotline to conduct an oversight review.

Results: We found that NIHCS leadership requested a fact-finding related to the complaint prior to receiving our January 15 request. In a document titled "Quality Management Service Fact-Finding Response Form," dated December 19 and 20, 2013, the fact finder determined the provider (b)(3):38 U.S.C. 5705
(b)(3):38 U.S.C. 5705 The recommendation went to human resources and then to risk management for concurrence and approval before NIHCS leadership (b)(6).

(b)(6)

(b)(6)

(b)(6)

The NIHCS Director told us the provider resigned from the facility effective early June and will not return to work at NICHS after June 28, 2014. The Director was informed the provider was selected for a job in Atlanta. The Director did not know if the job is with VA and stated the (b)(6) (b)(6) (b)(6)

Conclusion: Ideally, the 3-month time period between the fact finder's (b)(6) (b)(6) and the (b)(6) (b)(6) and the need for risk management and human resources review. We determined NIHCS leadership initiated appropriate fact-finding actions prior to our review and completed (b)(6) (b)(6) Consequently, I am administratively closing this case. We have no recommendations.

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7/21/14
(b)(6) not in outlook as of this date.
Atlanta