Administrative Closure
Temporary Closure of the Cardiothoracic Surgery Program
Oklahoma VA Medical Center (XXX/00)
Oklahoma City, OK
MCI # 2014-04480-HI-0577

On June 26, 2014, inspectors from the VA Office of Inspector General (OIG) Office of Healthcare inspections conducted an unannounced site visit to the Oklahoma City VA Medical Center (VAMC) in response to allegations reported in the media that the VAMC's cardiothoracic (CT) surgery program was temporarily closed because five patients had died post-surgically since October 2013. An anonymous complainant had previously reported concerns about CT surgery mortality rates to the OIG's Hotline Division on March 27, 2014. Because the allegations contained minimal detail, the OIG referred the issue to the VAMC Director for review and written response back to the OIG.

During the OIG's unannounced site visit, inspectors interviewed the VAMC Associate Director (who was acting for the VAMC Director), the Chief of Staff, the Associate Director for Patient Care Services, the External Accreditation Coordinator/Acting Chief Quality Manager, and the Patient Safety Manager. Inspectors also reviewed surgical mortality data, peer reviews, credentialing and privileging files for the CT surgeons, and the electronic health records for the six patients who were identified.

VAMC clinical managers provided background on the VAMC's CT surgery program and described what steps they had taken in response to the allegations previously sent by the OIG and more explicitly described by the media. Specifically, VAMC clinical managers reported that:

- In response to the OIG hotline referral in March 2014, the VAMC conducted peer reviews for the five patients who underwent thoracic or open heart surgery at the VAMC from October 1, 2013, through March 31, 2014. Four of the peer reviews were conducted by cardiac surgeons not affiliated with the Oklahoma City VAMC, and one was conducted by a [redacted] who was not involved in the patient's case.

- The VAMC voluntarily "paused" CT surgeries twice in the past 2 years.

  - The first pause was in late 2012 following the departure of the CT Chief. This pause, which lasted about 4 months, occurred while new staff were recruited for the program. During the pause, patients continued to be seen in outpatient clinics, all consults were responded to, and the cardiac catheterization lab remained open.
  - The second pause occurred on June 9, 2014 following the death of a patient within 24 hours of CT surgery. On June 10, 2014, VAMC leadership submitted an "Issue Brief" to the Veterans Health Administration (VHA) through the Veterans Integrated Service Network (VISN). As of June 26,

2014, the CT surgery program remained paused until the program is reviewed by VHA's National Surgery Office in early July. During this pause, other VA facilities in the VISN have been instructed not to refer patients to the VAMC for CT surgery. However, CT program staff continue to see patients in clinic and are responding to consults.

Based on the information obtained during the OIG's unannounced site visit, we do not recommend further review of the VAMC CT surgery program at this time because appropriate quality reviews are in progress. VAMC leadership will provide us with updated information following the site review by VHA's NSO in early July.

Based on our review, I am administratively closing this case.

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Healthcare Inspections