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Administrative Closure Report
Healthcare Inspection, Hiring Practices and Surgical Service Issues
VA Illiana Health Care System Danville, Illinois
MCI# 2008-01325-HI-0091

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection at the VA Illiana Health Care System at the request of Senator Barack Obama. Anonymous complainants made allegations concerning the system's hiring practices and issues in the Surgical Service.

Background

Located in Danville, IL, the system provides a broad range of inpatient and outpatient services. Outpatient care is also provided at community based outpatient clinics located in Decatur, Peoria, and Springfield, IL, and in West Lafayette, IN. The system is part of Veterans Integrated Service Network (VISN) 11 and serves a veteran population of about 150,000 residing in central Illinois and west central Indiana.

Anonymous complainants sent a letter to Senators Richard Durbin and Barack Obama and to the former Secretary of Veterans Affairs, R. James Nicholson. The complainants alleged:

- An incompetent surgeon and physicians were appointed to leadership positions based on racial and religious preferences of senior managers.
- The (b)(6) had a history of poor performance in the private sector prior to his VA appointment, was hired because he was a neighbor of the (b)(6) (b)(6), is known to be a "breast surgeon" when most operations at the system are of other types, has a history of unprofessional and hostile behavior, is incompetent with most surgeries limited to minor procedures, does not carry the same workload as the other two general surgeons, is incapable of performing non-surgical procedures such as endoscopies, and is known to have attendance issues.
- The (b)(6) was selected over other more qualified applicants, and lacks skill in patient care and in teaching medical students and residents.
- The (b)(6) was promoted to a newly-created position of (b)(6) for pay incentives and to influence committee selections for management's benefit.
- A pathologist was appointed as the (b)(6) and was not trained or qualified in Imaging, without consideration for the clinician who had functioned as the Acting Chief of Imaging Service for 15 years.

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- A physician was selected for an appointment in long term care and is being "groomed" to become the Chief of Long Term Care.
- A (b)(6) was appointed by the Chief of Staff despite concerns from physicians.
- The Chief of Staff had a secret and lucrative financial deal with the local private group of radiologists who pushed for the VA appointment of (b)(6) (b)(6).

The former Secretary of Veterans Affairs also received an inquiry from Senator Obama regarding the same allegations. Their summary response was drafted, reviewed by system and VISN 11 Directors, and was directed to Senator Obama in a letter dated January 30, 2008, signed by the Deputy Under Secretary for Health for Operations and Management (DUSHOM).

Background

We conducted on-site inspections March 24–27 and April 2–4, 2008. Additional telephone interviews with key staff were completed on April 7 and 22, 2008. We reviewed previous congressional inquires and responses, credentialing and privileging folders, official personnel folders, meeting minutes, Equal Employment Opportunity (EEO) files, time and attendance records, operating room schedules, select quality management reports, Reports of Contact, and supervisory files containing counseling and disciplinary actions. We also conducted select computerized patient record system reviews of select patients' medical records, patient incident reports, and peer review proceedings.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency. (www.ignet.gov)

Also, an OIG team conducted a separate inspection at the system on December 3–5, 2007. The purpose of that inspection was to investigate alleged physician credentialing and privileging irregularities and background issues. Anonymous complainants alleged that the (b)(6) should not have been appointed to this position in the system due to his incompetence and a history of poor performance in the private sector. The complainants also alleged that (b)(6) was selected over another "excellent" surgeon who already had many years of established "good" work. During that site visit, we conducted extensive reviews of credentialing and privileging processes and files, official personal folders, performance evaluations, education and training records, patient adverse event disclosure records, and Professional Standards Board proceedings. These allegations were not substantiated, and there were no recommendations.

Results

In our most recent inspection, we could not substantiate or refute:

- Th(b)(6)
- Key management positions were filled due to racial or religious preferences of senior managers.
- (b)(6)

We substantiated that:

- The (b)(6) had a lesser clinical workload than the other surgeons, but this was because of the Chief's administrative performance requirements.
- (b)(6) (b)(6)
- The (b)(6) was not trained in Imaging; however, the position did not exclusively require that clinical expertise.
- (b)(6)

We did not substantiate that:

- (b)(6)

An inquiry from Senator Obama to the Secretary of Veterans Affairs dated December 6, 2007 was reviewed and acted upon by the Deputy Under Secretary for Health for Operations and Management (DUSHOM) in conjunction with the VISN 11 and the Acting System Directors. We identified a discrepancy between the DUSHOM's summary of findings and those determined by the OIG team. Management did not acknowledge or disclose all of the problems in their response to the Senator. During the

course of this inspection, we also identified specific patients whose care warranted further review.

We discussed all of these issues with the former and acting VISN 11 Director to ensure that the newly appointed System Director requires that the continuity of patient care be maintained through effective staff communication and collaboration.

Further, we requested that the former and acting VISN Director ensure that the System Director requires that supervisors and managers appropriately accept and process staff complaints and initiate disciplinary action when necessary.

We also asked the DUSHOM to consider establishing improved processes to ensure that complaints are acted upon with integrity and thoroughness.

We requested that VHA managers perform an independent review of the identified patients' care issues that we found and make recommendations based on their findings.

We made no recommendations.

Prepared by: _____//es//_____ Date: June 17, 2008
Verena Briley-Hudson
Director (54CH)

Recommend Approval/Disapproval

_____ Date: _____
Dana L. Moore, PhD
Deputy Assistance Inspector General
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Approved/Disapproved

_____ Date: 7/1/08
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Discussed w Sen Obama's staff 7/8/08