Administrative Closure
Alleged Cardiology and Administrative Issues
Phoenix VA Health Care System
(2009-03665-HI-0213)

The Department of Veterans Affairs, Office of Inspector General, Office of Healthcare Inspections reviewed allegations regarding cardiology and administrative issues at the Phoenix VA Health Care System, Phoenix, AZ. The anonymous complainant notified the OIG Hotline, requesting a review of the allegations.

The complainant alleged that a staff cardiologist performed certain cardiology procedures without appropriate qualifications. The complainant further alleged that the cardiologist has inappropriate relationships with vendors and that some system staff referred patients to a cardiology specialist at the Southern Arizona VA Healthcare System to ensure safe patient care.

Review Results

We conducted an inspection on October 26-27, 2009. We reviewed credentialing and privileging (C&P) documents, cardiology procedure data for fiscal year (FY) 2009, Veterans Health Administration and system policies and procedures, patient advocate and quality management information, and various related reports. We also reviewed the appropriateness of cardiology procedures referred by system clinicians to the Tucson VA. We interviewed key system senior leaders and staff, including the cardiologist. We did not substantiate the allegations.

Conclusions

We concluded that the cardiologist had appropriate credentials and privileges for the procedures performed. We also concluded that patient referrals were appropriate. We did not find evidence of inappropriate interactions with vendors. Since we did not substantiate the allegations, we made no recommendations. Therefore, we are closing this case without making recommendations or issuing a formal report.

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