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VETERANS HEALTH ADMINISTRATION

Deficiencies in Credentialing, Privileging, and Evaluations for Surgeons at the St. Cloud VA Medical Center in Minnesota

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate facility leaders' response to surgical care concerns related to two facility surgeons at the St. Cloud VA Medical Center (facility) in Minnesota. In late June 2024, the OIG received a complaint alleging two facility surgeons, surgeon A and surgeon B, were harming patients and that facility leaders failed to respond to quality of care concerns by removing "the surgeons from surgical duties."

On July 10, 2024, the OIG initiated a healthcare inspection to evaluate facility leaders' response to the reported surgical care concerns for the two facility surgeons. The OIG found the facility leaders' response generally met Veterans Health Administration (VHA) requirements. Facility leaders suspended the identified surgeons from performing surgical procedures in the operating room and completed clinical reviews and privileging actions.[1]

During the review, the OIG identified additional concerns related to clinical privileges and professional practice evaluations for the medical staff, including a physician in a leadership position, and facility leaders' compliance with state licensing board (SLB) reporting.

Failure to Verify Previous Surgical Experience of a Newly Hired Surgeon

VHA's privileging process ensures providers are clinically competent to independently provide patient care. Clinical privileges are based on evidence of current competence supported by documentation in the credentialing record, which includes education, training, and licensure.[2] The facility privileging application form requires evidence of at least 100 procedures completed in the past 24 months to be submitted as support of competence.

The OIG determined that the surgical service chief failed to ensure that surgeon A's application for privileges included recent surgical case volume and case mix as required.

The OIG reviewed surgeon A's procedure case logs and found no documentation supporting operative experience during the year that followed residency. The OIG learned surgeon A performed 39 surgical procedures preceding employment at the facility, 61 cases short of the 100-case requirement. During an interview with the OIG, the surgical service chief recalled a conversation with surgeon A in which surgeon A's lack of experience and insufficient case numbers were discussed. However, the OIG found no documented evidence that a deviation from the requirements outlined in the facility application for privileges form was requested, discussed, or reviewed with other facility leaders by the surgical service chief or during Medical

[1] Within this report, the OIG used the terms *procedures* and *cases* interchangeably to represent surgeries that patients undergo.

[2] VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

Staff Executive Council (MSEC) meetings. During the inspection, the surgical service chief acknowledged not requesting surgeon A's surgical case logs until notification of the inspection by the OIG, approximately a year after hiring surgeon A. In early spring 2023, as recommended by the surgical service chief and the MSEC, the Facility Director approved surgeon A's privileging application, despite not meeting the case requirement of 100 cases to verify competence.

As a result of the surgical service chief's failure to review surgeon A's previous surgical case logs, facility leaders were not afforded a clear understanding of surgeon A's surgical experience and competency on which to base their decision for medical staff privileges, potentially placing patients at risk for harm.

Ineffective Use of Initial Focused Professional Practice Evaluation

A focused professional practice evaluation (FPPE) is a time-limited process whereby clinical leaders evaluate the privilege-specific competence of a provider who does not have documented evidence of competence in performing the requested privilege at the facility.[3] The clinical service chief is responsible for defining specialty-specific FPPE criteria to be utilized in monitoring clinical performance of providers granted privileges to include review of patient records, direct observation, and peer review.[4]

The OIG learned that the FPPE plan for surgeon A to demonstrate competency in performing operations included monitoring surgeon A through direct observation of all procedures. Instead, the surgical service chief reported that a review of electronic health records was completed in mid-fall 2023. Based on the results of the electronic health record review, the surgical service chief recommended surgeon A be transitioned from an FPPE to an ongoing professional practice evaluation (OPPE), and the MSEC approved the recommendation.[5]

The OIG determined that, although a plan for monitoring surgeon A included direct observation during the initial FPPE period, surgeon A was not directly observed to ensure competency with surgical procedures. Additionally, the electronic health record review did not include operating

[3] VHA Directive 1100.21(1); VHA Medical Staff Affairs Quality, Safety, and Value, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, January 2018; Facility Bylaws, Rules, and Regulations of the Medical and Clinical Professional Staff approved November 17, 2021. Facility Bylaws, Rules, and Regulations of the Medical and Clinical Professional Staff approved December 1, 2023. Unless otherwise specified, the November 17, 2021, bylaws contain the same or similar language as the December 1, 2023, bylaws. Within this report, the executive committee of the medical staff is referred to as the MSEC, which is the term used in the facility bylaws.

[4] VHA Directive 1100.21(1); VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a "a critical review of care performed by a peer" "to promote confidential and non-punitive assessments of care at the individual clinician level."

[5] VHA Directive 1100.21(1). OPPE is "The ongoing monitoring of privileged LIPs [licensed independent practitioners] to identify clinical practice trends that may impact the quality and safety of care."

room surgical procedures, and thus did not fully evaluate surgeon A's scope of privileges.[6] The OIG concluded that the surgical service chief's determination regarding surgeon A's ability to safely perform as a staff surgeon was based on insufficient information.

Deficiencies in Ongoing Professional Practice Evaluations

VHA requires that all medical staff members with clinical privileges are subject to OPPE, regardless of specialty, through a process developed by the respective facility service chief, with the consent of the MSEC, and final approval by the medical center director.[7] The results of an OPPE do not dictate privileging actions, but are used for the MSEC to propose privileging actions such as renewal of clinical privileges or initiation of an FPPE for cause.[8]

The OIG determined facility surgeons' OPPEs reviewed only procedures completed in the surgical outpatient clinic and did not include the evaluation of operating room surgical procedures.

The OIG learned through interviews that facility staff identified that the facility surgeons' operating room procedures were not re-incorporated into OPPEs following changes made during the COVID-19 pandemic, revealing an ongoing process that did not fully monitor the practice of facility surgeons.[9] As a result, the OIG learned that facility leaders completed a gap analysis related to facility credentialing and privileging processes. Through the gap analysis, facility leaders identified a need for corrective actions to include clinical indicators incorporated into OPPEs for surgeons. As a result of this identified gap, in late summer 2024, facility leaders resumed inclusion of operative procedures performed in the ambulatory surgery center as part of the OPPE process.

The OIG is concerned that the failure to include all aspects of the surgeons' practice limited facility leaders' ability to ensure the effectiveness of the professional evaluation processes and processes used to monitor the quality of surgical care and promote patient safety. Without representation of such an important aspect of surgeons' practices, the information reviewed to

[6] As noted in the following section of this report, facility surgeons' operating room procedures were not re-incorporated into OPPEs following changes made during the COVID-19 pandemic. The OIG learned the same form was used for FPPEs.

[7] VHA Directive 1100.21(1).

[8] VHA Directive 1100.21(1).

[9] Facility staff reported to the OIG that during the COVID-19 pandemic, elective surgery was suspended in the ambulatory surgery center (the primary facility operating rooms), and professional practice evaluations were limited to the review of clinic procedures; VHA Directive 1100.21(1); VHA Medical Staff Affairs Quality, Safety, and Value, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, January 2018. VHA requires the criteria to incorporate into the OPPE to be defined in advance. The process may include "direct observation, clinical discussions, simulation and clinical pertinence reviews that, if documented, can also be incorporated into the OPPE process. Data must be provider-specific, reliable, easily retrievable, timely, justifiable, comparable, and risk-adjusted where appropriate."

assess performance and ensure competency was incomplete, leaving a central component of the surgeon's practice unreviewed.

Additional Concern: Privileging Deficiencies of the Surgical Service Chief

VHA policy dictates that the "*VA medical facility Chief of Surgery must be credentialed and privileged in the practice of surgery at the VA medical facility*" (italics in the original).[10] The initial FPPE process applies to all newly privileged providers, regardless of whether they will hold a leadership position. The evaluation is an oversight process that permits a provider to demonstrate competent performance of privileged care as part of the initial employment process at the facility.[11]

The OIG found that the surgical service chief was clinically inactive and performed no surgical procedures at the facility until early spring 2023, despite being granted surgical privileges at the facility from the date of hire in late spring 2021.

The OIG found that the surgical service chief was first granted surgical privileges and placed on an FPPE in late spring 2021, concurrently with starting at the facility. Since the surgical service chief did not start providing clinical care at the facility until early spring 2023, the initial FPPE was not completed until early summer 2023, over two years later. The surgical service chief reported intervening duties such as the need to reestablish the surgical program after the COVID-19 pandemic and serving in additional leadership roles.[12]

The OIG concluded the surgical service chief was clinically inactive for the first two years of employment. As a result, facility leaders had no ability to ensure the competent clinical performance of the surgical service chief. Despite the mitigating circumstances, the OIG would have expected the surgical service chief to have clinical responsibilities from the outset and complete an initial FPPE timely, as is expected of all new facility medical staff members.

Summary Suspension and Focused Clinical Care Reviews

The OIG found facility leaders responded to allegations of quality of care concerns related to two surgeons. In early summer 2024, due to the reports of surgical care concerns, the Chief of Staff temporarily reassigned the surgeons to provide only outpatient clinic services, pending completion of investigations related to performance of surgical duties.

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[10] VHA Directive 1102.01(2), *National Surgery Office*, April 24, 2019, amended April 19, 2022.

[11] VHA Directive 1100.21(1); VHA Medical Staff Affairs Quality, Safety, and Value, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, January 2018.

[12] According to email correspondence, the surgical service chief was detailed as Acting Administrative Director, Diagnostic ICC late spring 2022–early fall 2022; Acting Chief of Staff early fall 2022–early 2023; and Acting Administrative Director, Diagnostics ICC early 2023–mid-spring May 2023.

The OIG learned that the following day, a case performed by surgeon A was sent for external peer review. An external peer reviewer completed a preliminary review of the case performed by surgeon A and based on the assessed quality of care concerns, encouraged facility leaders to initiate an administrative review. In response, the Facility Director issued a summary suspension letter to surgeon A and initiated a focused clinical care review (FCCR).[13]

In early summer, approximately two weeks after initiation, the FCCR for surgeon A was completed and reviewers found surgeon A generally did not meet the standard of care.[14] In mid-summer, the surgical service chief recommended removal of surgeon A from federal service. However, a summary review board in late fall did not find evidence of clinical care concerns supporting removal from federal service.[15] The OIG reviewed documentation provided by the summary review board, which commented on the FCCR, noting the use of two expert reviewers rather than three as suggested, but not required, by VHA.[16] Further, the summary review board emphasized the importance of using reviewers who also practiced in an environment with clinical and administrative support similar to surgeon A. As a result, in late 2024, surgeon A was issued a notification that the summary suspension was rescinded and surgeon A would be returned to clinical care duties.

In response to clinical care concerns for surgeon B, in early summer 2024, the Facility Director issued a letter to surgeon B, reassigning surgeon B to "out-patient services" pending a review of performance of duties.[17] A consult with VHA credentialing and privileging program office leaders resulted in the Chief of Staff issuing a letter of investigation to review surgeon B's practice without suspending privileges, and an FCCR was initiated in mid-summer 2024.

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[13] VHA Directive 1100.21(1). A summary suspension is an action taken by a facility director to suspend clinical privileges "when the failure to take such action may result in an imminent danger to the health of any individual" if the provider continues to engage in clinical practice. VHA Directive 1100.21(1); An FCCR is a comprehensive review of a provider's practice for which there is an identified concern or issue.

[14] VHA Medical Staff Affairs Quality, Safety, and Value, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, January 2018. VHA policy suggests the FCCR be conducted by three reviewers of similar specialty and practice. Through a review of documents, the OIG learned that two VHA providers (expert reviewers) completed the FCCR. The facility provided the reviewers the same two index cases for review, and individually split for review 30 additional randomly selected cases. The reviewers only concurred on one of the index cases that surgeon A had not met the standard of care, and opined that the standard of care was not met in 10 of the 30 cases reviewed.

[15] VA Directive 5021, *Employee Management Relations*, April 15, 2002; VA Handbook 5021/29, PART III. Probationary Period Actions, September 24, 2024. A summary review board is "a group of title 38 employees who assess the separation or retention of a probationary title 38 employee." Title 38 employees are healthcare providers, including physicians, and are subject to a two-year probationary period.

[16] VHA Medical Staff Affairs Quality, Safety, and Value, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, January 2018.

[17] Facility Bylaws, Rules, and Regulations of the Medical and Clinical Professional Staff. The immediate supervisor, in this case the Chief of Staff, typically would conduct a "preliminary review of the alleged clinical deficiencies to determine whether a comprehensive focused clinical care review or other administrative review is warranted."

In early fall 2024, the FCCR for surgeon B concluded that surgeon B met the standard of care in cases reviewed. As a result, the Credentialing Committee, as recommended by the surgical service chief, approved surgeon B to return to all clinical practice duties.

The OIG found facility leaders generally met the VHA requirements for summary suspension notifications and initiation of FCCRs for surgeons A and B.[18] The OIG concluded that facility leaders followed the VHA directive and facility medical bylaws to complete the FCCRs, in response to clinical concerns reported by facility staff, to assess whether surgeons A and B provided safe patient care.

Deficiencies in State Licensing Board Reporting

The OIG determined that facility leaders failed to initiate reporting of surgeon A to the SLB when clinical care concerns were identified in surgeon A's FCCR.

VHA states, "SLB reporting must be initiated as soon as there is substantial evidence of the provider significantly failing to meet the generally accepted standards of clinical practice to raise reasonable concern for the safety of patients."[19] VHA policy does not require a final administrative action take place prior to reporting to an SLB.[20] Further, it is the facility director, and not the summary review board, that decides whether there is evidence of clinical care concerns warranting reporting to SLBs.[21]

The Facility Director denied receiving guidance or participating in discussions regarding SLB reporting of surgeon A. Both the surgical service chief and the credentialing and privileging manager told the OIG that SLB reporting depended on the decision of the summary review board.

While the summary review board "did not identify evidence of clinical care concerns warranting reporting" to the SLB for surgeon A, the OIG would have expected facility leaders to initiate reporting of surgeon A to the SLB after receiving the completed FCCR in early summer 2024 and not wait for a subsequent administrative review by the summary review board.

The OIG made four recommendations to the Facility Director related to comprehensive review of surgical service credentialing and privileging processes; OPPEs and FPPEs; and SLB reporting processes.

[18] VHACO Medical Staff Affairs, "Summary Suspensions of Privileged Practitioners," (Standard Operating Procedure – P9), July 14, 2021.

[19] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

[20] VHA Directive 1100.18.

[21] VHA Directive 1100.18.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes A and B). Based on information provided, the OIG considers recommendation 4 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

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Abbreviations

FCCR	focused clinical care review
FPPE	focused professional practice evaluation
MSEC	Medical Staff Executive Council
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
SLB	state licensing board
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate facility leaders' response to surgical care concerns related to two facility surgeons at the St. Cloud VA Medical Center (facility) in Minnesota.

Background

The facility, part of Veterans Integrated Service Network (VISN) 23, has VA clinics in Alexandria, Brainerd, and Montevideo, Minnesota. The facility provides services in primary medical, subspecialty medical, urgent care, mental health, acute psychiatry, extended care, and rehabilitation. From October 1, 2022, through September 30, 2023, the facility served 37,260 unique patients. The facility has 272 operating beds, including 15 acute psychiatry beds, 92 domiciliary operating beds, and 165 community living center beds. The Veterans Health Administration (VHA) classifies the facility as level 3, low complexity.[1]

The facility's surgical complexity is categorized as "ambulatory procedure center basic," offering same day orthopedic, oral, and general surgery procedures.[2] The facility does not provide medical inpatient or intensive care services, and while the facility has an urgent care center, acute patient issues that arise on the facility campus are often transferred to a higher-level medical center or local community emergency department for further care.[3]

Allegations and Concerns

In late June 2024, the OIG received a complaint alleging two facility surgeons, surgeon A and surgeon B, were harming patients and that facility leaders failed to respond to quality of care concerns by removing "the surgeons from surgical duties." The OIG reviewed the allegations and initiated a healthcare inspection on July 10, 2024, to evaluate facility leaders' response to the reported surgical care concerns for the two facility surgeons. During the course of the review, the OIG identified additional concerns related to clinical privileges and professional practice evaluations for the medical staff, including a physician in a leadership position, and facility leaders' compliance with state licensing board (SLB) reporting.

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[1] VHA Office of Productivity, Efficiency and Staffing (OPES), "Facility Complexity Model Fact Sheet," January 28, 2021. The VHA Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, and educational and research missions. "The model rates facilities as 1a, 1b, 1c, 2, or 3, with facilities rating 1a being the most complex and those rated 3 the least complex." A level 3 facility has "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs."

[2] VHA Directive 1220(1), *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in any Clinical Setting*, May 13, 2019, amended February 11, 2020.

[3] VHA Directive 1220 (1); Facility Policy SOP (standard operating procedure) CD11-76.6, *SSC INTER-Facility Transfers*, October 26, 2021.

Scope and Methodology

The OIG conducted an on-site visit from September 10 through 12, 2024. Virtual interviews were conducted from July 11, 2024, through September 25, 2024. The OIG interviewed VISN and facility leaders and relevant staff.

The OIG reviewed applicable VHA directives and handbooks, facility policies related to credentialing and privileging and patient safety, facility committee meeting minutes, quality and management review documents, and other relevant documents. The OIG also reviewed, for adverse clinical outcomes, the electronic health records of patients for whom facility staff reported clinical care concerns and cases reviewed in focused clinical care reviews (FCCRs).

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

The OIG determined facility leaders responded to reported quality of care concerns related to two surgeons. Facility leaders suspended the identified surgeons from performing surgical procedures in the operating room and completed clinical reviews and privileging actions.[4] The OIG determined that the facility leaders' actions in response to quality of care concerns related to the two surgeons generally met VHA requirements; therefore, the OIG does not have related recommendations.

[4] Within this report, the OIG used the terms *procedures* and *cases* interchangeably to represent surgeries that patients undergo.

However, the OIG found deficiencies in facility leaders' oversight of the credentialing and privileging of surgeons, resulting in failure to monitor for and detect patient care concerns, potentially presenting risks to patient safety. Specifically, the OIG identified deficiencies in facility leaders' compliance with requirements for verification of qualifications and monitoring of initial and ongoing professional practice evaluations (OPPEs). The OIG also identified concerns with the surgical service chief's approved privileges and facility leaders' compliance with SLB reporting.

1. Deficiencies in Credentialing, Privileging, and Professional Practice Evaluations

Failure to Verify Previous Surgical Experience of a Newly Hired Surgeon

The OIG determined that the surgical service chief failed to ensure that surgeon A's application for privileges was completed per facility requirements. Specifically, the surgical service chief did not review surgeon A's recent surgical case volume and case mix.

VHA defines credentialing as "the process of obtaining, verifying, and assessing the qualifications of a health care provider to provide care or services in or for the VA health care system."[5] According to VHA, the privileging process ensures providers are clinically competent to independently provide patient care. Clinical privileges are based on evidence of current competence supported by documentation in the credentialing record, which includes education, training, and licensure.[6] A provider must be credentialed before being privileged or permitted to provide patient care independently, within the scope of the individual's license, based on clinical competence, experience, education, and training.[7] The facility's Chief of Staff is responsible for overseeing the credentialing and privileging program, and ensures credentialing activities are monitored.[8] The facility's clinical service chief is responsible for reviewing a provider's credentialing and privileging documentation and recommends the provider for medical staff appointment to the Medical Staff Executive Council (MSEC).[9] After review and approval by the MSEC, the MSEC Chair recommends to the Facility Director whether or not a healthcare

[5] VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2001.

[6] VHA Directive 1100.21 (1), *Privileging*, March 2, 2023, amended April 26, 2023.

[7] VHA Directive 1100.21(1); VHA Directive 1100.20.

[8] VHA Directive 1100.20.

[9] VHA Directive 1100.21(1); Facility Bylaws, Rules, and Regulations of the Medical and Clinical Professional Staff approved November 17, 2021. Facility Bylaws, Rules, and Regulations of the Medical and Clinical Professional Staff approved December 1, 2023. Unless otherwise specified, the November 17, 2021, bylaws contain the same or similar language as the December 1, 2023, bylaws. Within this report, the executive committee of the medical staff is referred to as the MSEC, which is the term used in the facility bylaws.

provider should be appointed to the medical staff.[10] The facility application form for requesting surgical privileges requires evidence of at least 100 procedures completed in the past 24 months to be submitted as support of competence.

The OIG reviewed credentialing documentation of surgeon A and found that while surgical training, license, certifications, work history, and references were verified by facility leaders and credentialing and privileging staff as required, details of surgeon A's recent operative experience were not.[11]

During an interview with the OIG, surgeon A reported communicating the inability to meet the facility's surgical experience criteria of 100 cases in the prior 24 months to the surgical service chief. According to surgeon A, the surgical service chief stated an exception to the requirement would be made. During an interview with the OIG, the surgical service chief recalled a conversation with surgeon A in which surgeon A's lack of experience and insufficient case numbers were discussed. The surgical service chief reported seeking the opinion of other facility surgeons, who supported hiring surgeon A despite the lack of surgical experience. The OIG found no documented evidence that a deviation from the requirements outlined in the facility application for privileges form was requested, discussed, or reviewed with other facility leaders by the surgical service chief or during MSEC meetings.

The OIG reviewed surgeon A's procedure case logs, which detailed extensive surgical experience during residency training, which ended in early summer 2021. The OIG found no documentation supporting operative experience during the year that followed residency while surgeon A was training as an intensivist. Surgeon A reported performing 39 surgical procedures preceding employment at the facility, 61 cases short of the 100-case requirement. The surgical service chief acknowledged not requesting surgeon A's surgical case logs until notification of the inspection by the OIG, approximately a year after hiring surgeon A.

The OIG found that, in early spring 2023, as recommended by the surgical service chief and MSEC, the Facility Director approved surgeon A's privileging application, despite not meeting the case requirement of 100 cases to verify competence.

The OIG concluded that the surgical service chief failed to follow the facility privileging application process by not requiring surgeon A to submit evidence of at least 100 completed operative procedures in the prior 24 months during the application for privileges process. As a result of the surgical service chief's failure to review surgeon A's previous surgical case logs, facility leaders were not afforded a clear understanding of surgeon A's surgical experience and

[10] VHA Directive 1100.20.

[11] VHA Directive 1100.20. Across the VHA enterprise, each facility uses a program called VetPro, which serves as a transparent repository of documentation of review of qualifications leading to a "uniform, accurate, and complete credentials file." The documentation is used to support and verify the training, licenses, certifications, and other information needed to determine if the applicant is qualified to deliver patient care.

competency on which to base their decision for medical staff privileges, potentially placing patients at risk for harm.

Ineffective Use of Initial Focused Professional Practice Evaluation

The OIG found the surgical service chief did not include direct observation in surgeon A's focused professional practice evaluation (FPPE) to evaluate competency in performing operations.

According to VHA policy and facility bylaws, FPPE is a time-limited process whereby clinical leaders evaluate the privilege-specific competence of a provider who does not yet have documented evidence of competently performing the requested privilege(s) at a facility.[12] The clinical service chief is responsible for defining specialty-specific FPPE criteria to be utilized in monitoring clinical performance of providers granted privileges.[13] The initial FPPE can include review of patient records, direct observation, and peer review.[14] Successful completion of the initial FPPE results in continued monitoring of a provider's quality of care through an OPPE.[15]

The OIG learned during document review that the FPPE plan was consistent with other surgeons and that "Monitoring will include observation of all procedures until competency is demonstrated." The surgical service chief told the OIG in an interview that a review of electronic health records was completed in mid-fall 2023 to monitor the professional practice of surgeon A; however, the review included only endoscopies performed in the ambulatory surgical clinic and did not include a review of surgical procedures completed in the operating room.[16] Additionally, through document review, the OIG learned that the surgical service chief recommended, based on the results of the electronic health record review, transitioning surgeon A from an FPPE to an OPPE at the MSEC meeting and the recommendation was approved.

The OIG concluded that, although a plan for monitoring surgeon A included direct observation during the initial FPPE period, surgeon A was not directly observed to ensure competency with surgical procedures. Additionally, the indirect monitoring strategy (the electronic health record review) used during the initial FPPE period did not include operating room surgical procedures,

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[12] VHA Directive 1100.21(1); VHA Medical Staff Affairs Quality, Safety, and Value, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, January 2018; Facility Bylaws, Rules, and Regulations of the Medical and Clinical Professional Staff.

[13] VHA Directive 1100.21 (1).

[14] VHA Directive 1100.21(1); VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a "a critical review of care performed by a peer" "to promote confidential and non-punitive assessments of care at the individual clinician level."

[15] VHA Directive 1100.21(1). OPPE is "The ongoing monitoring of privileged LIPs [licensed independent practitioners] to identify clinical practice trends that may impact the quality and safety of care."

[16] As noted in the following section of this report, facility surgeons' operating room procedures were not re-incorporated into OPPEs following changes made during the COVID-19 pandemic. The OIG learned the same form was used for FPPEs.

and thus did not fully evaluate surgeon A's scope of privileges. Further, the OIG concluded that the surgical service chief's determination regarding surgeon A's ability to safely perform as a staff surgeon was based on insufficient information.

Deficiencies in Ongoing Professional Practice Evaluations

The OIG determined that facility surgeons' OPPEs reviewed only procedures completed in the surgical outpatient clinic and did not include the evaluation of operating room surgical procedures.

VHA policy requires that all medical staff members with clinical privileges are subject to OPPE, regardless of specialty, through a process developed by the respective facility service chief, with the consent of the MSEC, and final approval by the medical center director.[17] The results of an OPPE do not dictate privileging actions, but are used for the MSEC to propose privileging actions such as renewal of clinical privileges or initiation of an FPPE for cause.[18]

During interviews and document reviews, the OIG learned that facility leaders and staff completed a gap analysis related to facility credentialing and privileging processes. The surgical service chief reported that facility leaders identified the gap in failing to include operative surgical procedures. Through document review and an interview, the OIG discovered that the Facility Director tasked relevant clinical leaders and staff to ensure that professional practice evaluations accurately represented the clinical practice of all facility surgeons and included surgical procedures. The OIG reviewed documentation of the gap analysis results, including findings and status of implementation of the corrective actions by facility leaders. Facility staff, including the Chief of Staff, reported to the OIG that during the COVID-19 pandemic, elective surgery was suspended in the ambulatory surgery center (the primary facility operating rooms), and professional practice evaluations were limited to the review of clinic procedures. Through the gap analysis, facility leaders identified a need for the following corrective actions related to credentialing and privileging concerns:

- Clinical indicators incorporated into OPPEs for surgeons
- The Credentialing Committee realigned to report to the MSEC
- Credentialing Committee and MSEC reporting requirements included in facility bylaws

The OIG found that two of three corrective actions related to surgical privileging processes were in the process of completion. The clinical indicators in OPPEs for surgeons were implemented in late summer 2024, with plans for the Credentialing Committee to begin reporting to MSEC in late 2024 and facility bylaws to reflect committee structure changes in early 2025.

[17] VHA Directive 1100.21(1).
[18] VHA Directive 1100.21(1).

The OIG learned through interviews that facility staff identified that the facility surgeons' operating room procedures were not re-incorporated into OPPEs, revealing an ongoing process that did not fully monitor the practice of facility surgeons.[19] As a result, in late summer 2024, facility leaders resumed inclusion of operative procedures performed in the ambulatory surgery center as part of the OPPE process.

The OIG determined that facility leaders failed to use professional practice evaluations consistent with VHA policy to monitor the care delivered by surgeons, as the reviews did not include surgical procedures performed in the operating room. Without representation of such an important aspect of surgeons' practices, the information reviewed to assess performance and ensure competency was incomplete, leaving a central component of the surgeon's practice unreviewed. The OIG is concerned that the failure to include all aspects of the surgeons' practice limited facility leaders' ability to ensure the effectiveness of the professional evaluation processes and processes used to monitor the quality of surgical care and promote patient safety.

Additional Concern: Privileging Deficiencies of the Surgical Service Chief

The OIG found that the surgical service chief was clinically inactive and performed no surgical procedures at the facility until early spring 2023, despite being granted surgical privileges at the facility from the date of hire in late spring 2021 as required.

VHA policy dictates that the "*VA medical facility Chief of Surgery must be credentialed and privileged in the practice of surgery at the VA medical facility*" (italics in the original).[20] For staff in leadership positions, the clinical privileging process is the same process as for all other members of the medical staff.[21] The evaluation is an oversight process that permits a provider to demonstrate competent performance of privileged care as part of the initial employment process at the facility.[22]

In an interview with the OIG, the surgical service chief described being out of clinical practice for over a year leading up to employment at the facility in late spring 2021. In reviewing the surgical service chief's privileging application, the OIG found that the surgical service chief was

[19] VHA Directive 1100.21(1); VHA Medical Staff Affairs Quality, Safety, and Value, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, January 2018. VHA requires the criteria to incorporate into the OPPE to be defined in advance. The process may include "direct observation, clinical discussions, simulation and clinical pertinence reviews that, if documented, can also be incorporated into the OPPE process. Data must be provider-specific, reliable, easily retrievable, timely, justifiable, comparable, and risk-adjusted where appropriate."

[20] VHA Directive 1102.01(2), *National Surgery Office*, April 24, 2019, amended April 19, 2022.

[21] VHA Directive 1100.21(1).

[22] VHA Directive 1100.21(1); VHA Medical Staff Affairs Quality, Safety, and Value, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, January 2018.

first granted surgical privileges and placed on an FPPE, concurrently with starting at the facility. Since the surgical service chief did not start providing clinical care at the facility until early spring 2023, the initial FPPE was not completed until early summer 2023, over two years later. When asked by the OIG about the delay in providing clinical services, the surgical service chief reported intervening duties such as the need to reestablish the surgical program after the COVID-19 pandemic and serving in additional leadership roles.[23]

The OIG concluded the surgical service chief was clinically inactive for the first two years of employment. As a result, facility leaders had no ability to ensure the competent clinical performance of the surgical service chief. Despite the mitigating circumstances, the OIG would have expected the surgical service chief to have clinical responsibilities from the outset and complete an initial FPPE timely, as is expected of all new facility medical staff members.

2. Facility Leaders' Response to Clinical Care Concerns

The OIG reviewed facility leaders' actions in response to reported quality of care concerns for two surgeons; specifically, removal of the identified surgeons from operative surgical procedures, completion of focused clinical care reviews, and privileging actions after facility leaders learned of the clinical concerns. The OIG determined that the facility leaders' actions to review quality of care for the two surgeons identified in the allegation generally met VHA standards.

The OIG learned through document review that in early summer 2024, due to the reports of surgical care concerns, the Chief of Staff temporarily reassigned the surgeons to provide only outpatient clinic services, pending completion of investigations related to performance of surgical duties. The OIG discovered that the Facility Director issued a summary suspension letter approximately one week later, notifying surgeon A that surgical privileges were suspended, and in mid-summer 2024, the Chief of Staff issued surgeon B a letter that an investigation of the surgeon's practice was being conducted, although privileges were not suspended.

Summary Suspension and Focused Clinical Care Reviews

Per VHA policy, a summary suspension is an action taken by a facility director to suspend clinical privileges "when the failure to take such action may result in an imminent danger to the health of any individual" if the provider continues to engage in clinical practice.[24] According to facility bylaws, "whenever there are concerns that a Practitioner has demonstrated substandard care, professional (clinical) misconduct, or professional (clinical) incompetence, further

[23] According to email correspondence, the surgical service chief was detailed as Acting Administrative Director, Diagnostic ICC late spring 2022–early fall 2022; Acting Chief of Staff early fall 2022–early 2023; and Acting Administrative Director, Diagnostics ICC early 2023–mid-spring 2023.

[24] VHA Directive 1100.21(1).

information will be gathered to either confirm or refute the legitimacy of the concerns."[25] The immediate supervisor typically would conduct a preliminary review of the clinical concerns "to determine whether a comprehensive focused clinical care review, or other administrative review is warranted."[26] Additionally, "Initiation of a summary suspension triggers the obligation to conduct a FCCR of the LIP's [licensed independent practitioner] practice."[27] According to VHA, an FCCR is a comprehensive review of a provider's practice for which there is an identified concern or issue.[28]

The OIG learned that in early summer, the risk manager, as directed by facility leaders, sent a case performed by surgeon A for external peer review. According to email correspondence, the peer reviewer at another facility within the VISN completed a preliminary review of the case performed by surgeon A and based on the assessed quality of care concerns, encouraged facility leaders to initiate an administrative review. In response, the Chief of Staff withdrew the request for a peer review. Two days later, the Facility Director issued a summary suspension letter to surgeon A and initiated an FCCR.

The FCCR for surgeon A was completed in early summer, approximately two weeks after initiation.[29] Reviewers found that, in 10 of the 30 cases (33 percent) reviewed, surgeon A did not meet the standard of care.[30] The OIG learned that following receipt of the FCCR results, the Facility Director issued a summary suspension extension letter, which removed surgeon A from all patient care duties. Additionally, in mid-summer 2024 , the surgical service chief recommended removal of surgeon A from federal service; however, a summary review board in late fall 2024 did not find evidence of clinical care concerns supporting removal from federal

[25] Facility Bylaws, Rules, and Regulations of the Medical and Clinical Professional Staff.

[26] Facility Bylaws, Rules, and Regulations of the Medical and Clinical Professional Staff.

[27] VHA Directive 1100.21(1).

[28] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018; VHA Directive 1190(1), *Peer Review for Quality Management*, amended July 19, 2024. Unless otherwise specified, the two directives contain similar language related to FCCR; VHA Medical Staff Affairs Quality, Safety, and Value, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, January 2018.

[29] During the inspection, the OIG learned that in late summer 2024, an issue brief identified additional concerns with clinical care during colonoscopies regarding identification of polyps and documentation of additional cases performed by surgeon A. A Clinical Episode Review Team (CERT) completed a review of clinical care and determined no patient harm identified, and no additional review of care required.

[30] VHA Medical Staff Affairs Quality, Safety, and Value, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, January 2018. VHA policy suggests the FCCR be conducted by three reviewers of similar specialty and practice. Through a review of documents, the OIG learned that two VHA providers (expert reviewers) completed the FCCR. The facility provided the reviewers the same two index cases for review, and individually split for review 30 additional randomly selected cases. The reviewers only concurred on one of the index cases that surgeon A had not met the standard of care, and opined that the standard of care was not met in 10 of the 30 cases reviewed.

service.[31] The OIG reviewed documentation provided by the summary review board, which commented on the FCCR, noting the use of two expert reviewers rather than three as suggested, but not required, by VHA.[32] Further, the summary review board emphasized the importance of using reviewers who also practiced in an environment with clinical and administrative support similar to surgeon A. The OIG learned through document review that the surgical service chief issued a letter in late 2024 notifying surgeon A that the summary suspension was rescinded and surgeon A would be returned to clinical care duties.

Through document review, the OIG discovered that in early summer, the Facility Director issued a letter to surgeon B, reassigning surgeon B to "out-patient services" pending a review of performance of duties.[33] During an interview, the OIG learned that in mid-summer 2024, at the direction of the VISN Chief Medical Officer, the Chief of Staff consulted with VHA credentialing and privileging program office leaders to obtain guidance whether an investigation of surgeon B could occur without issuing a summary suspension.[34] As a result of the discussions, the Chief of Staff issued a notification letter to surgeon B that a review of the surgeon's practice was being conducted. An FCCR was initiated approximately 10 days later.

The FCCR for surgeon B concluded in early fall 2024, and the reviewers found that in 58 of the 60 cases reviewed (96.7 percent), surgeon B met the standard of care. The FCCR results were presented to the Credentialing Committee two weeks later, and the surgical service chief recommended returning surgeon B to all clinical practice duties, at which time the Credentialing Committee approved the recommendation.

The OIG found facility leaders generally met the VHA requirements for summary suspension notifications and initiation of FCCRs for surgeons A and B.[35] The OIG concluded that facility leaders followed the VHA directive and facility medical bylaws to complete the FCCRs, in response to clinical concerns reported by facility staff, to assess whether surgeons A and B

[31] VA Directive 5021, *Employee Management Relations*, April 15, 2002; VA Handbook 5021/29, *PART III. Probationary Period Actions,* September 24, 2024. A summary review board is "a group of title 38 employees who assess the separation or retention of a probationary title 38 employee." Title 38 employees are healthcare providers, including physicians, and are subject to a two-year probationary period.

[32] VHA Medical Staff Affairs Quality, Safety, and Value, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, January 2018.

[33] Facility Bylaws, Rules, and Regulations of the Medical and Clinical Professional Staff. The immediate supervisor, in this case the Chief of Staff, typically would conduct a "preliminary review of the alleged clinical deficiencies to determine whether a comprehensive focused clinical care review or other administrative review is warranted."

[34] VHA Directive 1100.21(1); VHA Medical Staff Affairs Quality, Safety, and Value, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, January 2018. A notice of investigation without a summary suspension can be issued if facility leaders determine there is a concern for a provider's clinical practice that warrants an FCCR, however, there is no concern that reached the level of "imminent danger" to patient safety if the provider continues to provide care during the review.

[35] VHACO Medical Staff Affairs, "Summary Suspensions of Privileged Practitioners," (Standard Operating Procedure – P9), July 14, 2021.

provided safe patient care. Therefore, the OIG does not have recommendations related to facility leaders' response to clinical care concerns.

3. Deficiencies in State Licensing Board Reporting

The OIG determined that facility leaders failed to initiate reporting of surgeon A to the SLB. Despite the summary review board findings disagreeing with the FCCR reviewers' findings, the OIG would have expected the SLB reporting process to be triggered by the FCCR results for surgeon A that found 10 of 30 cases reviewed did not meet the standard of care.

"VA has broad authority to report to SLBs those currently appointed or separated licensed health care professionals whose behavior or clinical practice substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients."[36] VHA policy for SLB reporting includes five stages: initial, comprehensive, decision, and privacy officer review, followed by the reporting stage with "suggested timeframes" of completion for each stage, but requires that the reporting be completed in less than 100-calendar days.[37]

VHA policy further states:

- "SLB reporting must be initiated as soon as there is substantial evidence of the provider significantly failing to meet the generally accepted standards of clinical practice to raise reasonable concern for the safety of patients."
- "Reporting must not wait until a personnel action has been completed [or] a related hearing process has concluded."[38]
- "The first- or second-line supervisor must initiate the SLB reporting process within 5-business days of obtaining objective evidence that the licensed health care professional failed to meet the generally acceptable standards of care."[39]
- "The Credentialing and Privileging Manager must be notified by the supervisor in no more than 7-business days of identification of substandard care so that the SLB reporting process can be immediately initiated."[40]
- The facility director is responsible for ensuring a comprehensive review has been initiated within 7-business days to determine whether, based on the objective evidence, there is substantial evidence the provider has failed to meet generally

[36] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.
[37] VHA Directive 1100.18.
[38] VHA Directive 1100.18.
[39] VHA Directive 1100.18.
[40] VHA Directive 1100.18.

> accepted standards of clinical practice. The facility director has the ultimate decision authority as to whether reporting to an SLB is warranted.[41]

During an interview with the OIG, the Facility Director denied receiving guidance or participating in discussions regarding SLB reporting of surgeon A. Both the surgical service chief and the credentialing and privileging manager told the OIG during interviews that SLB reporting depended on the decision of the summary review board. Additionally, the VISN credentialing and privileging officer informed the OIG, reporting to an SLB would occur once a final administrative action was taken by facility leaders.

The OIG learned through document review that the summary review board "did not identify evidence of clinical care concerns warranting reporting to State Licensing Boards at this time." VHA policy does not require a final administrative action take place prior to reporting to an SLB.[42] Further, it is the facility director, and not the summary review board, that decides whether there is evidence of clinical care concerns warranting reporting to SLBs.[43]

Despite the disagreement between the summary review board and FCCR reviewers, the OIG concluded that facility leaders failed to initiate reporting of surgeon A to the SLB after receiving the completed FCCR in early summer 2024 with evidence the provider failed to meet generally accepted standards of clinical practice. The OIG would have expected, based on the results of surgeon A's FCCR, that the surgical service chief would have timely notified the facility credentialing and privileging manager to initiate the SLB reporting procedure, and the Facility Director would have ensured the reporting steps were followed.

Conclusion

The OIG determined that the surgical service chief failed to ensure that surgeon A's application for privileges was completed per facility requirements. While surgical training, license, certifications, work history, and references were verified by facility leaders and credentialing and privileging staff as required, details of surgeon A's recent operative experience were not. As a result of the surgical service chief's failure to review surgeon A's previous surgical case logs, facility leaders were not afforded a clear understanding of surgeon A's surgical experience and competency on which to base their decision for medical staff privileges, potentially placing patients at risk for harm.

The OIG found the surgical service chief did not include direct observation in surgeon A's FPPE to evaluate competency in performing operations. Although a plan for monitoring surgeon A included direct observation during the initial FPPE period, surgeon A was not directly observed

[41] VHA Directive 1100.18.
[42] VHA Directive 1100.18.
[43] VHA Directive 1100.18.

to ensure competency with surgical procedures. Therefore, the surgical service chief's determination regarding surgeon A's ability to safely perform as a staff surgeon was based on insufficient information.

The OIG determined that facility surgeons' OPPEs did not include the evaluation of operating room surgical procedures. Facility leaders and staff completed a gap analysis related to facility credentialing and privileging processes and identified the failure to include operative surgical procedures. However, the OIG is concerned that the failure to include all aspects of the surgeons' practice limited facility leaders' ability to ensure the effectiveness of the professional evaluation processes and processes used to monitor the quality of surgical care and promote patient safety.

The OIG found that the surgical service chief was clinically inactive and performed no surgical procedures at the facility until early spring 2023 despite being granted surgical privileges at the facility from the date of hire in late spring 2021 as required. The surgical service chief reported the delay was due to intervening duties such as the need to reestablish the surgical program after the COVID-19 pandemic and serving in additional leadership roles. Because the surgical service chief did not have clinical responsibilities from the outset, facility leaders had no ability to ensure the competent clinical performance of the surgical service chief.

The OIG found facility leaders generally met the VHA requirements for summary suspension notifications and initiation of FCCRs for surgeons A and B. Facility leaders also followed VHA directive and facility policy guidance to complete the FCCRs, in response to clinical concerns reported by facility staff, to assess whether surgeons A and B provided safe patient care.

The OIG determined that facility leaders failed to initiate reporting of surgeon A to the SLB and would have expected the SLB reporting process to be triggered by the FCCR results for surgeon A and not wait for a subsequent administrative review by the summary review board.

Recommendations 1–4

1. The St. Cloud VA Medical Center Director completes a comprehensive review of surgical service credentialing and privileging processes, ensures facility policy and practice in alignment with Veterans Health Administration policy, and as necessary, consults with Veterans Integrated Service Network leaders, and monitors for compliance.

2. The St. Cloud VA Medical Center Director reviews the processes specific to ongoing professional practice evaluations, ensures alignment with Veterans Health Administration policy, including surgical service chief consideration of the use of specialty-specific metrics, including surgical procedures performed in the operating room, and monitors compliance.

3. The St. Cloud VA Medical Center Director completes a review of Medical Staff Executive Council meeting minutes, specific to focused and ongoing professional practice evaluations for the surgical service chief, identifies deficiencies, and takes action as warranted to ensure completion according to Veterans Health Administration requirements.

4. The St. Cloud VA Medical Center Director, in conjunction with Veterans Integrated Service Network leaders, ensures that Veterans Health Administration state licensing board reporting processes are followed for surgeon A consistent with Veterans Health Administration Directive 1100.18.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 7, 2025

From: Executive Director, VA Midwest Healthcare Network (VISN23/10N23)

Subj: VAOIG DRAFT REPORT — Deficiencies in Credentialing, Privileging, and Evaluations for Surgeons at the St. Cloud VA Medical Center in Minnesota

To: VA Office of Inspector General

1. This memo is in response to the VAOIG DRAFT REPORT - Deficiencies in Credentialing, Privileging, and Evaluations for Surgeons at the St. Cloud VA Medical Center in Minnesota.

2. I concur with the Medical Center's review of the case.

3. If you have further questions or concerns, please contact the St. Cloud VA Health Care System Executive Director.

(*Original signed by:*)

Robert P. McDivitt, FACHE
Executive Director
VA Midwest Healthcare Network (VISN 23)

[OIG comment: The OIG received the above memorandum from VHA on May 22, 2025.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 17, 2025

From: Director, St. Cloud VA Medical Center (656)

Subj: Deficiencies in Credentialing, Privileging, and Evaluations for Surgeons at the St. Cloud VA Medical Center in Minnesota

To: Director, VA Midwest Health Care Network (10N23)

1. Thank you for the opportunity to review and respond to the Office of Inspector General draft report of the St. Cloud VA Health Care System in Minnesota.

2. I reviewed the report and concur with recommendations 1-4. The attached action plan has been developed or implemented and are identified in the Director Comments. I request the closure of recommendation 4.

3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.

(*Original signed by*:)

Cheryl Thieschafer
St. Cloud VA Health Care System Director

[OIG comment: The OIG received the above memorandum from VHA on May 22, 2025.]

Facility Director Response

Recommendation 1

The St. Cloud VA Medical Center Director completes a comprehensive review of surgical service credentialing and privileging processes, ensures facility policy and practice in alignment with Veterans Health Administration policy, and as necessary, consults with Veterans Integrated Service Network leaders, and monitors for compliance.

_X _Concur

____Nonconcur

Target date for completion: June 2025

Director Comments

A comprehensive review of the St. Cloud Medical Center credentialing and privileging processes was completed in August 2024, and action plans are in progress. The Chief of Quality and Patient Safety will report the Comprehensive Review Action Plan to the Quality and Patient Safety Council monthly until complete.

The Integrity and Compliance Officer also completed the fiscal year 2025 credentialing and privileging facility self-assessment on January 31, 2025, and an action plan to address those deficiencies is in progress.

The Credentialing and Privileging Manager will report the status of the Credentialing and Privileging Facility Self-Assessment action plan to the Integrity and Compliance Committee monthly until complete.

Recommendation 2

The St. Cloud VA Medical Center Director reviews the processes specific to ongoing professional practice evaluations, ensures alignment with Veterans Health Administration policy, including surgical service chief consideration of the use of specialty-specific metrics, including surgical procedures performed in the operating room, and monitors compliance.

_X _Concur

____Nonconcur

Target date for completion: August 2025

Director Comments

The initial review and corrective actions were taken specific to ongoing professional practice evaluations and implemented in September 2024.

The Chief of Quality and Patient Safety will audit compliance of 100% of surgical service provider ongoing professional practice evaluations for the inclusion of specialty-specific metrics and surgical procedures in the operating room for two quarters and report results to the Quality and Patient Safety Council.

The Medical Center Director and Chief of Staff will conduct a review of the surgical service chief's specialty-specific metrics, including surgical procedures performed in the operating room, and determine if any privileging or adverse actions need to be taken. Privileging actions and professional practice evaluations will be reported to the Credentialing and Privileging Committee and the Medical Staff Executive Council.

Recommendation 3

The St. Cloud VA Medical Center Director completes a review of Medical Staff Executive Council meeting minutes, specific to focused and ongoing professional practice evaluations for the surgical service chief, identifies deficiencies, and takes action as warranted to ensure completion according to Veterans Health Administration requirements.

_X _Concur

____Nonconcur

Target date for completion: August 2025

Director Comments

The Medical Center Director and Chief of Staff will conduct a review of the Credentialing and Privileging Committee and Medical Staff Executive Council minutes targeted specifically to review focused and ongoing professional practice evaluations for the surgical service chief. Upon the completion of the review, the Director and Chief of Staff will identify any deficiencies and determine actions to be taken.

Recommendation 4

The St. Cloud VA Medical Center Director, in conjunction with Veterans Integrated Service Network leaders, ensures that Veterans Health Administration state licensing board reporting processes are followed for surgeon A consistent with Veterans Health Administration Directive 1100.18.

_X _Concur

____Nonconcur

Target date for completion: December 2024

Director Comments

VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, states, "Under the routine use, VA may alert a state licensing board (SLB) of incidents suggesting substandard care, without naming the licensed health care professional, and indicate that the Evidence File may be provided pursuant to a qualifying law enforcement request." Furthermore, National VA SOP-P9, *Suspension of Privileged Practitioners*, indicates summary suspensions are not reportable to the SLB in and of themselves. The Chief of Staff and Surgical Service Chief did not recommend notification to the SLB, however; operating room privileges were suspended, pending the investigation. The Summary Review Board convened on December 10, 2024, and determined care met the standard of care and was not reportable. VHA Directive 1100.18 and SOP-P9 were reviewed, and reporting processes were followed throughout the investigation. The St. Cloud VA Medical Center Director, in conjunction with Veterans Integrated Service Network leaders, consider this recommendation fully implemented and request OIG consider closure.

OIG Comments

The OIG considers this recommendation closed.

OIG Contact and Staff Acknowledgments

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