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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Provider Oversight and Privileging Processes at the Carl Vinson VA Medical Center in Dublin, Georgia

HEALTHCARE INSPECTION | **REPORT #19-07828-265** | **SEPTEMBER 28, 2020**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection of the Carl Vinson VA Medical Center (facility) in Dublin, Georgia, after receiving a referral from OIG inspectors regarding facility leaders' response to a report that a urologist had severe hand tremors and possibly low visual acuity.[1] The purpose of the inspection was to determine whether facility leaders identified and managed incidents of adverse clinical outcomes related to the urologist's surgical practice and to evaluate facility leaders' oversight and privileging of the urologist.[2] During the inspection, the OIG identified two additional concerns: noncompliance with Veterans Health Administration (VHA) directives regarding reporting physicians to the National Practitioner Data Bank and state licensing boards, and the impact of frequent facility leader turnover.

The OIG identified two adverse clinical outcomes in 121 of the urologist's surgical patients, neither of which required an increased level of care and did not result in long-term impact. The OIG determined that the complications were appropriately managed by the urologist, reported through the patient safety reporting system, and acted upon. But the OIG determined that facility leaders failed to adequately oversee the performance of the urologist. Facility leaders did not formally evaluate a report that the urologist had severe hand tremors and low visual acuity that could have posed a risk to patient safety.

Although two focused professional practice evaluations and a clinical care review of the provider were completed, the OIG found deficiencies in the processes used that further demonstrated failures in facility leaders' oversight processes. The OIG also found that none of the evaluations were used to inform Medical Executive Committee recommendations to the Facility Director regarding the urologist's privileges.

Facility leaders mishandled three opportunities to reduce the urologist's privileges, first as an unprocessed voluntary request by the urologist, then as an unexecuted instruction from the Acting Chief of Staff, and finally as a privileging action by the Medical Executive Committee that failed to provide mandatory notification to the urologist or note why the action was taken.[3]

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[1] The OIG Comprehensive Healthcare Inspection Program inspectors conducted a site visit at the facility in February 2019.

[2] In the context of this report, the OIG defines an adverse clinical outcome as any incident, complication, or adverse event related to a surgical intervention, regardless of the incident, complication, or adverse event being a known risk or leading to an increased level of care.

[3] Although the urologist officially had full privileges until February 26, 2019, the urologist reported believing an October 2018 request to reduce full privileges to only non-open procedure privileges was approved. The urologist only completed non-open procedures after the request was made.

The OIG determined that the lapses led to delays in removing the urologist's privilege to perform open procedures and a failure to keep the urologist informed of actual privileges.

Facility leaders did not comply with VHA directives that require reporting adverse privileging actions to the National Practitioner Data Bank and reporting patient safety concerns to state licensing boards. The OIG found, as a result of noncompliance with the reporting directives, patient safeguards intended to be achieved through reporting were impeded.

Frequent personnel changes in the facility director and chief of staff positions could have contributed to the failures in facility leaders' oversight, privileging, and practitioner reporting processes. During the period from September 1, 2018, to April 1, 2019, the facility experienced five separate instances of acting facility directors, had four different acting chiefs of staff and a permanent and an acting chief of surgery. The leaders' noncompliance with facility and VHA policies likely occurred due to poor communication regarding the urologist's practice and privileging status, a lack of knowledge of position responsibilities, and inexperienced support staff.

The deficiencies found in the focused professional practice evaluation processes and National Practitioner Data Bank reporting were consistent with issues identified by the OIG Comprehensive Healthcare Inspection Program team. The recommendations relevant to this report have been closed. Duplicative recommendations were not made regarding these issues.[4]

The OIG made the following recommendations to the Veterans Integrated Service Network 7 and Facility Directors:

1. The Veterans Integrated Service Network 7 Director ensures Carl Vinson VA Medical Center leaders, in permanent or acting roles, are knowledgeable about and compliant with the oversight of medical staff, including those with possible physical impairments.[5]
2. The Veterans Integrated Service Network 7 Director ensures Carl Vinson VA Medical Center leaders, in permanent or acting roles, are knowledgeable about and compliant with privileging policies.
3. The Veterans Integrated Service Network 7 Director ensures Carl Vinson VA Medical Center leaders, in permanent or acting roles, are knowledgeable about and compliant with state licensing board reporting policies.

[4] VA OIG, *Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center, Dublin, Georgia*, Report No. 18-04682-256, November 12, 2019.

[5] Facility MCM 11-80, *Health Status and Impaired Professional Program*, November 29, 2016. "Impairment. The inability or immediately impending inability of a health professional to practice his/her health profession in a manner which conforms to the minimum standards of acceptable and prevailing practice for that profession due to the health professional's substance abuse, chemical dependency, physical, or mental illness."

4. The Carl Vinson VA Medical Center Director evaluates concerns that the urologist has a possible physical impairment, consults with Human Resources, and takes action, if indicated.
5. The Carl Vinson VA Medical Center Director reviews current clinical care review processes, identifies areas of noncompliance with Medical Center Bylaws & Medical Staff Rules, and takes action to ensure compliance.
6. The Carl Vinson VA Medical Center Director reviews current reduction of privileges processes, identifies areas of noncompliance, and takes action to ensure compliance with Veterans Health Administration policy.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

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Contents

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
COS	Chief of Staff
EHR	electronic health record
FPPE	focused professional practice evaluation
MEC	Medical Executive Committee
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection of the Carl Vinson VA Medical Center (facility) in Dublin, Georgia, after receiving a referral from OIG inspectors regarding facility leaders' response to a report that a urologist allegedly had severe hand tremors and possibly low visual acuity that may require corrective lenses.[6] The purpose of this inspection was to determine whether facility leaders identified and managed incidents of adverse clinical outcomes related to the urologist's surgical practice as well as complied with Veterans Health Administration (VHA) and facility policies related to oversight and privileging of the urologist.[7]

Background

The facility, part of Veterans Integrated Service Network (VISN) 7, is composed of a medical center in Dublin and six community-based outpatient clinics. VA classifies the facility as a Level 2, medium level complexity facility.[8] From October 1, 2017, through September 30, 2018, the facility served 36,991 patients and provided acute and extended care services.

Comprehensive Healthcare Inspection Program Referral

OIG Comprehensive Healthcare Inspection Program (CHIP) inspectors conducted a review of the facility in February 2019.[9] During the CHIP review, inspectors met with the Credentialing and Privileging Coordinator (Coordinator) and Chief of Quality, Safety, and Value to review medical staff privileging and requested a report on providers who had a focused professional

[6] A urologist is a specialist who treats conditions of the urinary or urogenital organs. The urologist at issue is a surgeon.

[7] In the context of this report, the OIG defines an adverse clinical outcome as any incident, complication, or adverse event related to a surgical intervention, regardless of the incident, complication, or adverse event being a known risk or leading to an increased level of care.

[8] The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex. Level 3 facilities are the least complex. VHA Office of Productivity, Efficiency and Staffing. http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. (The website was accessed May 3, 2019, and is an internal VA website not publicly accessible.)

[9] VA OIG, *Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center, Dublin, Georgia*, Report No. 18-04682-256, November 12, 2019. VA Office of Inspector General, "Publications," Oversight Reports. CHIP reviews are part of the OIG's overall efforts to ensure that the nation's veterans receive high-quality VA healthcare services. The reviews focus on key clinical and administrative processes and are performed approximately every three years for each facility. https://www.va.gov/oig/publications/default.asp. (The website was accessed March 6, 2020.)

practice evaluation (FPPE) for cause.[10] The CHIP inspectors received information about a urologist who, while the facility was conducting an FPPE for cause due to patient safety concerns, was reported by a surgical proctor as experiencing severe hand tremors during a surgical procedure.[11] At the time of the CHIP inspection, the facility had completed the FPPE for cause and had initiated an FPPE. A clinical review was pending, and according to the urologist's privileging file, the urologist was permitted to continue to perform open surgeries.

Prior OIG Reports

In the *Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center, Dublin, Georgia* report, published on November 12, 2019, the OIG identified deficiencies with FPPE processes as well as with reporting adverse privileging actions to the National Practitioner Data Bank. FPPE processes did not include defining evaluation criteria before initiating the evaluation or evidence of the results of evaluations.[12] Additionally, the facility failed to report an adverse privileging action to the National Practitioner Data Bank. In response to the OIG recommendations for these issues, the Facility Director established an improvement plan. The recommendations relevant to this report have been closed.

OIG Concerns

Based on the issues referred by CHIP inspectors, the OIG opened an inspection to review the following concerns:

1. Identification and management of adverse clinical outcomes in patients who underwent surgical procedures by the urologist
2. Oversight of the urologist, including evaluation of the reported impairments and clinical performance[13]

[10] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. Credentialing is a "systematic process of screening and evaluating qualifications and other credentials, including, but not limited to licensure, required education, relevant training and experience, and current competence and health status." Clinical privileging is the process by which an independently licensed practitioner is legally permitted by the facility to provide specified medical or other patient care services. Reprivileging must be conducted at least every two years. Facility, *Medical Center Bylaws & Medical Staff Rules,* December, 2016. There are two types of FPPEs: initial FPPEs and FPPEs for cause. Both types of FPPEs are intended to permit assessment of a provider's competence. For the purpose of this report, initial FPPEs are referred to as standard FPPEs.

[11] VHA Handbook 1100.19. "Proctoring is the activity by which a practitioner is assigned to observe the practice of another practitioner performing specified activities and to provide required reports on those observations."

[12] VA OIG, *Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center, Dublin, Georgia.*

[13] Facility MCM 11-80, *Health Status and Impaired Professional Program*, November 29, 2016. "Impairment. The inability or immediately impending inability of a health professional to practice his/her health profession in a manner which conforms to the minimum standards of acceptable and prevailing practice for that profession due to the health professional's substance abuse, chemical dependency, physical, or mental illness."

3. Privileging of the urologist[14]

During the inspection, the OIG identified two additional concerns regarding facility leaders' compliance with VHA policies to report health care professionals to the National Practitioners Data Bank and state licensing boards (see section 4—Failure to Comply with National Practitioners Data Bank and State Licensing Board Reporting Directives) as well as the impact of frequent leadership changes on oversight and privileging processes (see section 5—Facility Leader Changes).

Scope and Methodology

On April 18, 2019, the OIG initiated the healthcare inspection in response to a CHIP referral. The OIG conducted initial interviews from July 9, 2019, through July 24, 2019. The OIG conducted additional interviews with facility staff as needed through February 20, 2020.

The OIG interviewed facility leaders and staff, including current and former Acting Chiefs of Staff (COS), Chief of Surgery, surgeons, operating room and urology clinic staff, Quality, Safety, and Value staff, credentialing and privileging staff, and the urologist. The OIG also interviewed the VHA Director of Medical Staff Affairs.

OIG staff reviewed relevant VHA and facility policies; the urologist's credentialing and privileging documentation, including professional practice evaluations and a clinical review; Medical Executive Committee (MEC) meeting minutes; documentation related to compliance with VHA National Practitioners Data Bank and state licensing board reporting directives and position changes of leaders; and emails regarding the matters under review. The OIG also reviewed 121 patient electronic health records (EHRs) and patient safety reports. The OIG completed a review of the urologist's operating room notes for the 95 patients who underwent surgery from January through October 2018 and whose operating room provider notes had been previously reviewed by a surgeon in VISN 7. The OIG also completed a review of the urologist's surgical procedures (operating room provider notes) for the 26 patients from October 20, 2018, through February 13, 2019, after the urologist stopped performing urological surgical procedures that required incisions. Criteria for these reviews included examination of the urologist's surgical operating room notes for any immediate adverse clinical outcomes or indications of issues during the procedures, such as abnormal bleeding or loss of blood from the incision, wrong site, and burns, if cautery was used.

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).

[14] VHA Handbook 1100.19.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). 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

1. Adverse Clinical Outcome Identification and Management

The OIG found that facility leaders identified and appropriately managed incidents of adverse clinical outcomes related to the urologist's performance. The OIG reviewed the EHRs of 121 of the urologist's surgical cases completed from January 1, 2018, through February 13, 2019. Specifically, the OIG reviewed 95 cases completed from January 1 through October 19, 2018, and 26 cases completed from October 20, 2018, through February 13, 2019.[15] The purpose of the EHR review was threefold:

1. To identify adverse clinical outcomes related to the urologist's surgical practice
2. To assess the clinical management of adverse clinical outcomes
3. To determine whether adverse clinical outcomes were reported and acted upon as patient safety events

The OIG reviewed 95 EHRs of patients who underwent open or non-open procedures between January 1, 2018, and October 19, 2018, the date of a proctor's report that the urologist had severe hand tremors and possibly low visual acuity due to possible need for corrective lenses. As shown in table 1, the procedures included 23 open and 72 non-open cases.

[15] Within this report, the OIG uses the terms procedures and cases interchangeably to represent surgeries that patients undergo. Open procedures are surgical cases that require an incision; non-open procedures are surgical cases that do not require an incision. The 95 surgical cases reviewed by the OIG included open and non-open procedures and were also the subject of a retrospective clinical care review conducted by a urologist from another VA. Results of the non-facility urologist's review are discussed in a subsequent section of this report (see Clinical Care Review). The 26 cases were non-open cases.

Table 1. OIG's Review of Cases from January 1 through October 19, 2018

Procedure[16]	Number Performed	Type of Procedure	Cases with Adverse Clinical Outcomes
Cystoscopy	8	Non-open	None noted
Prostate Biopsy	63	Non-open	None noted
Hydrocelectomy	2	Open	None noted
Circumcision	13	Open	2
Vasectomy	4	Open	None noted
Scrotal Sebaceous Cyst Removal	4	Open	None noted
Urinary Catheter Insertion	1	Non-open	None noted

Source: OIG analysis of 95 EHRs

The OIG identified two patients who experienced adverse clinical outcomes that did not require an increased level of care and did not result in long-term impact. Nursing staff correctly reported the occurrences as patient safety events. Additionally, the OIG identified that the facility took actions as a result of the reported adverse clinical outcomes. Specifically, the first occurrence, which occurred in August 2018, formed part of the rationale for placing the urologist on an FPPE for cause. A second patient experienced adverse clinical outcomes in October 2018. This case was directed to be included in a retrospective clinical care review.[17]

To ascertain whether safe patient care was provided during the time that the urologist no longer performed open procedures, the OIG reviewed each of the 26 surgical cases that the urologist completed between October 20, 2018, the date the urologist requested to withdraw privileges for open procedures, and February 13, 2019. As shown in table 2, the urologist only completed non-open procedures, none of which resulted in an adverse clinical outcome.

[16] A cystoscopy is a surgical procedure using a tube with a camera to insert into the urinary tract to visualize the lining of the tract and bladder. https://medlineplus.gov/ency/imagepages/1089.htm. (The website was accessed May 7, 2020.) A prostate biopsy is a procedure that removes cells or tissue from the prostate in order to test for cancer. https://medlineplus.gov/ency/article/007665.htm. (The website was accessed May 7, 2020.) A hydrocelectomy is a surgical procedure to remove a fluid filled sac in the scrotum. https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=hydrocelectomy. (The website was accessed September 25, 2019.) Circumcision is a surgical procedure to remove the foreskin on the tip of the penis. https://medlineplus.gov/circumcision.html. (The website was accessed September 25, 2019.) A vasectomy is a surgical procedure that cuts the tubes that carry sperm out of the testicles. https://medlineplus.gov/vasectomy.html. (The website was accessed September 25, 2019.) Sebaceous cyst is a sac under the skin filled with yellowish oily material. https://medlineplus.gov/ency/article/000842.htm. (The website was accessed May 7, 2020.) A urinary catheter is a tube placed in the body to drain and collect urine from the bladder. https://medlineplus.gov/ency/article/003981.htm. (The website was accessed May 7, 2020.)

[17] Throughout the inspection, the retrospective clinical care review was also referred to as a focused clinical review, clinical review, and comprehensive review in interviews and a summary suspension letter. For the purpose of this report, the review is referred to as a clinical care review. The process and results of the review are discussed in section 2.

Table 2. OIG's Review of Cases from October 20, 2018, through February 13, 2019

Procedure	Number Performed	Type of Procedure	Cases with Adverse Clinical Outcomes
Cystoscopy	2	Non-open	None noted
Prostate Biopsy	23	Non-open	None noted
Excision small skin piece	1	Non-open	None noted

Source: OIG Staff Review

The OIG identified two patients with adverse clinical outcomes through the review of the urologist's 121 surgical cases, and the urologist appropriately managed the adverse clinical outcomes. Additionally, the OIG found that facility staff reported the adverse clinical outcomes as patient safety events, and facility leaders acted upon the reports.

2. Deficiencies in Facility Leader Oversight

The OIG found deficiencies in facility leaders' oversight of the urologist. Although facility leaders were alerted that patient safety may have been jeopardized due to the urologist having severe hand tremors and possibly low visual acuity in October 2018, facility leaders did not conduct a formal evaluation of the accuracy of this information due to a lack of understanding of policies regarding physical examinations when suspected issues arose. Facility leaders did, however, perform professional practice evaluations, a clinical review, and a reduction of the urologist's privileges. The OIG found deficiencies with the procedures used for each of these processes. As shown in figure 1, the reviews and privileging processes overlapped, and for approximately four months, the urologist had full privileges despite having an uninvestigated physical impairment(s).[18]

[18] Although the urologist officially had full privileges until February 26, 2019, the urologist reported believing an October 2018 request to reduce full privileges to only non-open procedure privileges was approved. The urologist only completed non-open procedures after the request was made.

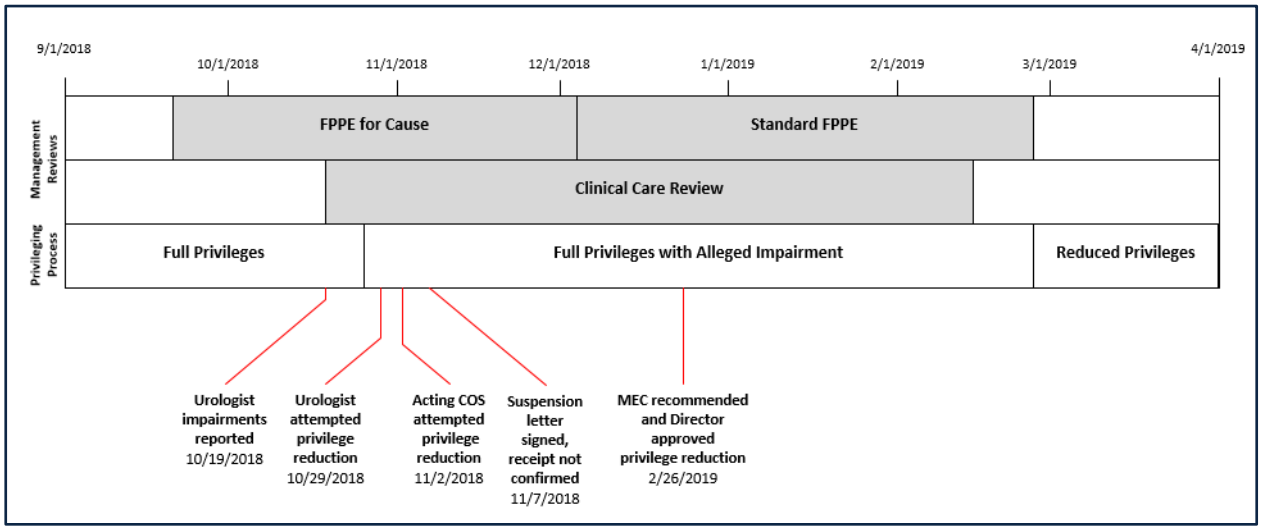

Figure 1. Privileging Processes and Management Reviews Concerning Urologist from September 2018 through April 2019
Source: Facility documents and interviews regarding privileging and management reviews of the urologist

Failure to Evaluate Physical Impairment Concerns

The OIG determined that facility leaders failed to formally evaluate the accuracy of statements regarding the urologist having physical impairments that could have impacted patient safety. Rather than evaluating whether the urologist had severe hand tremors and low visual acuity, facility leaders suggested a private medical evaluation of the reported impairments and accepted the urologist's assertion that there were no performance problems. During interviews with the OIG, facility leaders were unclear about their authority to evaluate suspected physical impairments.

VHA seeks to ensure that "employed personnel are physically, cognitively and emotionally fit to perform the duties of the position to which assigned."[19] Facility policy states that "any individual within the organization has the responsibility to report concerns regarding unsafe treatment by practitioners."[20] The COS is responsible for evaluating the credibility of a concern about an impaired provider.[21] Although VHA does not prescribe a particular method to evaluate a concern about a provider's physical impairment, facility policy and the *Medical Center Bylaws & Medical Staff Rules* (Bylaws) permit the facility director to authorize a special physical examination to evaluate a provider's fitness for duty.[22] Specifically, these medical examinations

[19] VHA Handbook 5019, *Employee Occupational Health Service*, March 27, 2015, revised August 3, 2017.
[20] Facility MCM 11-80, *Health Status and Impaired Professional Program*, November 29, 2016.
[21] Facility MCM 11-80.
[22] VHA Handbook 5019. Facility, *Medical Center Bylaws & Medical Staff Rules*. Facility MCM 11-80.

"may be required to solve questions of physical, cognitive or emotional ability to perform the essential duties of a position satisfactorily."[23]

During an interview with the OIG, the Acting COS reported that while serving as the Acting Deputy COS, she and the then Interim COS participated in a review of a surgical complication involving the urologist at issue in September 2018.[24] The Acting COS reported that, after the review, facility leaders were concerned about the urologist's competency and safety in the operating room. The Acting COS recalled that there were frequent conversations about the urologist having "tremors or some physical impairment," but stated there was no "report." The Acting COS reported that the September 2018 decision to place the urologist on an FPPE for cause with a proctor and to initiate a clinical care review was triggered by a concern for patient safety.

As part of the FPPE for cause, the proctor observed the urologist performing four surgical procedures. On October 19, 2018, the proctor emailed the Chief of Surgery and described having to step in to complete an open procedure that the urologist was unable to complete independently due to severe hand tremors and possibly low visual acuity. The proctor speculated that physical impairments may be the cause of the urologist's surgical complications. The proctor made the following recommendations to the Chief of Surgery. The urologist should

- No longer perform surgical procedures that require the use of a cautery device or sutures
- Undergo neurological and eye examinations
- Be proctored by another surgeon[25]

After the Chief of Surgery discussed the proctor's report with the urologist, the urologist requested to cease performing procedures that required an incision. The Chief of Surgery forwarded the proctor's email with a proposal for next steps to the Acting COS (who was still in the role of Acting Deputy COS) that included eliminating procedures requiring an incision from the urologist's workload. The Chief of Surgery also reported "unofficially" advising the urologist to get a "medical evaluation and possible help to address the cause of new tremors and possible vision problems."

During an interview with the OIG, the Chief of Surgery reported not believing "the service line has the right" to require a medical examination unless the practitioner's duties are "hampered." When the OIG asked about actions taken in response to the proctor's report that the urologist had

[23] VHA Handbook 5019.

[24] The Acting Chief of Staff referred to throughout this report was the Acting Deputy Chief of Staff during the months of September and October 2018. The Acting Chief of Staff occupied the position from November 3, 2018, through January 22, 2019.

[25] During an OIG interview, the proctor suggested that the urologist may have a neurological condition but acknowledged not being a neurologist.

tremors, the Acting COS reported not being "sure where that fine line was with [the urologist]" and trying to "balance between being intrusive into the physician's private issues versus…what was safe for the patient."

Facility leaders failed to formally evaluate statements that the urologist had physical impairments. Although the Chief of Surgery expressed doubt that the service line could mandate a medical examination unless the practitioner's duties were "hampered," the OIG considered an impairment of a surgeon that affected the ability to perform surgeries to represent a hampering of duties. Additionally, the Acting COS did not recognize the authority to pursue an evaluation of the possible physical impairments. Although facility leaders did not conduct a formal evaluation of the urologist's reported physical impairments, two FPPEs and a clinical review were completed as well as a reduction in the urologist's privileges. The OIG found deficiencies with each of these processes that further demonstrated failures in facility leaders' oversight processes.

Failures in Focused Professional Practice Evaluations

The OIG determined that two FPPEs of the urologist failed to comply with VHA and facility policies regarding initiating and closing these evaluations.

An FPPE is a type of management review of a practitioner's ability to safely perform privileges.[26] There are two types of FPPEs.[27] A standard FPPE is required anytime a provider is given a new privilege.[28] This type of FPPE is required for providers who are new to a facility and for existing providers who receive new privileges.[29] The evaluation is an oversight process that permits a practitioner to demonstrate competent performance of privileged care.[30] An FPPE for cause may be used when a concern is identified regarding a practitioner's ability to provide safe, quality patient care.[31] The evaluation is an opportunity for a practitioner to demonstrate improvement.[32]

VHA policy requires that both types of FPPEs be initiated with objective criteria to address specific competency indicators. The evaluation plan must be accepted by the provider, recommended by the service chief and MEC, and approved by the facility director.[33] Prior to concluding an FPPE, the results of the evaluation must be documented in the provider's

[26] 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, revision 3*.

[27] Facility, *Medical Center Bylaws & Medical Staff Rules*. There are two types of FPPEs: initial FPPEs and FPPEs for cause. For the purpose of this report, the initial FPPE is referred to as a standard FPPE.

[28] Facility, *Medical Center Bylaws & Medical Staff Rules*.

[29] Facility, *Medical Center Bylaws & Medical Staff Rules*.

[30] VHA Medical Staff Affairs Quality, Safety, and Value, *Provider Competency and Clinical Care Concerns.*

[31] Facility, *Medical Center Bylaws & Medical Staff Rules*.

[32] VHA Medical Staff Affairs Quality, Safety, and Value, *Provider Competency and Clinical Care Concerns.*

[33] VHA Handbook 1100.19.

privileging file, and reported to the MEC so that the MEC may make privileging recommendations to the facility director.[34] Practitioners who successfully complete an FPPE have routine performance monitoring through an ongoing professional practice evaluation. Practitioners who do not successfully complete an FPPE may have an adverse privileging action.[35]

FPPE Initiations

The urologist was placed on an FPPE for cause with a proctor in September 2018 and a standard FPPE in December 2018. The initiations of the two FPPEs did not comply with VHA policy. Despite the evaluations having different purposes, facility staff used the same form with pre-populated criteria for the for cause and standard FPPEs. The FPPE forms did not indicate the specific clinical concerns, customized performance indicators, or outcome expectations. Although the Acting COS informed the OIG that the September FPPE for cause was prompted by concerns about the urologist's competency and safety in the operating room, the form did not indicate any specific safety concern. Additionally, despite not receiving new privileges, the urologist was placed on a standard FPPE in December.

FPPE for Cause Closure

Neither of the FPPE closures were based on accurate information. In December 2018, the FPPE for cause proctor attended the MEC meeting as the alternate to the Chief of Surgery and presented the FPPE for cause results. The proctor recommended that the urologist's FPPE for cause be completed with the "caveat of [the urologist] will no longer have privileges for open surgeries." However, the Acting COS mistakenly reported to the MEC that the urologist's privileges already had been reduced for cause. This inaccurate statement likely led to the MEC not making a recommendation to the Facility Director regarding the urologist's privileges. The MEC recommended, and the Facility Director approved, placing the urologist on an FPPE for 90 days with a 30-day proctorship.

Standard FPPE Closure

In February 2019, the Acting Chief of Surgery presented the standard FPPE results to the MEC. The MEC recommended, and the Facility Director approved, converting the standard FPPE to an ongoing professional practice evaluation. The OIG examined the standard FPPE documentation and found that the evaluation sections of the form were blank, and there was no documentation that the competencies were met. Additionally, although a 30-day proctorship was to be included

[34] VHA Handbook 1100.19.

[35] VHA Medical Staff Affairs Quality, Safety, and Value, *Provider Competency and Clinical Care Concerns.* An ongoing professional practice evaluation is "the ongoing monitoring of privileged providers to confirm the quality of care delivered and ensures patient safety."

in the standard FPPE, the OIG did not receive evidence that a proctor observed the urologist's performance.

In the *Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center, Dublin, Georgia* report, published on November 12, 2019, the OIG described similar deficiencies in service chiefs' FPPE processes, including: criteria were not defined in advance; expectations were not communicated to providers; and evidence of review results was not maintained. The Coordinator reported to the CHIP team that a "lack of attention to detail resulted in incomplete documentation and contributed to the service chiefs' noncompliance." The OIG CHIP team made recommendations regarding FPPE processes and the Facility Director implemented an improvement plan. Therefore, recommendations addressing FPPE deficiencies were not made in this report.[36]

Clinical Care Review

The OIG identified flaws in the process used to retrospectively review the urologist's clinical performance after facility staff identified a concern for patient safety in September 2018.

VHA describes a clinical care review as a "provider specific comprehensive clinical care review of a specific area of practice, a specific time period of practice, or both, for which there is an identified concern or issue."[37]

Facility Bylaws indicate that when a practitioner's ability to provide safe, quality patient care is questioned, the COS may initiate a "comprehensive focused clinical review."[38] The COS is responsible for identifying the reviewer(s) and establishing the methodology to be used.[39] When there is an imminent concern for the safety of patients, the COS may recommend a full or partial suspension of the practitioner's privileges to the director. The practitioner must be notified of the initiation of the review as well as the potential to be reported to the National Practitioners Data Bank.[40] The results of the review must be presented to the MEC, who in turn recommends next steps to the facility director. The MEC recommendation may be to take no further action, to initiate an FPPE, or to pursue an adverse privileging action.[41]

During an OIG interview, the Acting COS reported making the decision to initiate a retrospective clinical care review based on concerns about the urologist's competency and safety in the operating room in September 2018, the same time the decision was made to place the

[36] Department of Veterans Affairs Office of Inspector General, *Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center, Dublin, Georgia.*

[37] VHA Medical Staff Affairs Quality, Safety, and Value, *Provider Competency and Clinical Care Concerns*.

[38] Facility, *Medical Center Bylaws & Medical Staff Rules*.

[39] Facility, *Medical Center Bylaws & Medical Staff Rules*.

[40] Facility, *Medical Center Bylaws & Medical Staff Rules*.

[41] Facility, Medical *Center Bylaws & Medical Staff Rules*.

urologist on an FPPE for cause. The Acting COS reported recruiting a urologist from another VA facility to conduct the review. In October 2018, the facility's Risk Manager emailed a list of all of the urologist's completed surgical cases from January 1, 2018, through October 19, 2018, and a request to the reviewer to assess EHRs for "any anomalies that may create concerns with the [s]urgeon's surgical performance." The email did not provide more specific criteria for the review, instructions for the report format, or the review's due date. A November 7, 2018, summary suspension letter addressed to the urologist contained required notifications of the review and its potential impact on privileges as well as reporting requirements and procedural due process rights.[42] During OIG interviews, however, the urologist reported not receiving the letter and the Chief of Surgery denied knowledge of the suspension. The Coordinator reported that the letter was sent to the urologist's home address, but there was no confirmation of receipt.

In February 2019, the Chief of Quality, Safety, and Value contacted the reviewer for a status update. The reviewer responded that "all cases appeared appropriate and were within the standard of care." The reviewer noted, however, questions regarding the urologist's ability to perform surgical procedures might require on-site observation. Although the results were returned prior to the February MEC meeting, the minutes from that meeting did not indicate the results were presented. The Chief of Surgery, who was the Acting COS and Chair of the MEC when the review result was returned, reported not being aware of the review until a July 2019 OIG interview.

Due to a failure to notify the urologist of the review, a lack of clear instructions for the reviewer, and the failure to discuss the review results with the MEC, the OIG concluded that the effectiveness of the review was limited. The deficiencies may be related to inexperience of the Risk Manager who reported that this was the first clinical care review experience and the Acting COS who assumed this role four days prior to the suspension letter being signed.

The OIG determined that facility leaders failed to adequately oversee the performance of the urologist by not formally evaluating an unconfirmed report that the urologist had physical impairments that might pose a risk to patient safety. Although facility leaders completed FPPEs and a clinical care review, the OIG found deficiencies in the processes used. Furthermore, the OIG found that the evaluations were not used to inform MEC recommendations to the Facility Director regarding the urologist's privileges.

3. Failures in Privilege Reduction Processes

Privileging is the process through which facility leaders grant a provider permission to independently deliver specific medical services within the scope of the provider's license. The

[42] Merriam-Webster, *Definition of Due Process*. "Procedural due process is adequate notice prior to the government's deprivation of one's life, liberty, or property, and an opportunity to be heard and defend one's rights to life, liberty, or property." https://www.merriam-webster.com/dictionary/due%20process. (The website was accessed April 21, 2020.)

OIG found that facility leaders failed to comply with VHA policies regarding reducing the urologist's privileges. Facility leaders mishandled three opportunities to reduce the urologist's privileges, first as an unprocessed voluntary request by the urologist, then as an unexecuted instruction from the Acting COS, and finally as a privileging action by the MEC that failed to provide mandatory notification to the urologist or note why the action was taken. The OIG determined that the lapses led to delays in removing the urologist's privilege to perform open procedures and a failure to keep the urologist informed of actual privileges.[43]

VHA mandates processes for voluntary and involuntary reductions in privileges.[44]

Urologist's Request to Voluntarily Reduce Privileges

VHA policy allows providers to request a modification to privileges at any time.[45] The provider's request for reduction of clinical privileges, supporting documents, and the credentialing and privileging file must be presented to the service chief for review, who then considers the request before making a recommendation to the MEC. The facility director considers MEC recommendations before making the final decision.[46] Figure 2 shows the process for a voluntary reduction of privileges.

[43] Although the urologist officially had full privileges until February 26, 2019, the urologist reported believing an October 2018 request to reduce full privileges to only non-open procedure privileges was approved. The urologist only completed non-open procedures after the request was made.

[44] VHA Handbook 1100.19.

[45] VHA Handbook 1100.19.

[46] VHA Handbook 1100.19.

Figure 2. VHA Process for Voluntary Reduction of Privileges[47]
Source: OIG review VHA Handbook 1100.19
Note: Gray denotes noncompliance with the step in the process.

The OIG found noncompliance with each of the steps mandated by VHA for the voluntary reduction of privileges. The OIG learned that, unbeknownst to the urologist, the Facility Director did not approve the request to voluntarily reduce the urologist's privileges.

During an interview with the OIG, the urologist reported voluntarily withdrawing privileges to perform open procedures and subsequently only performed non-open procedures, such as biopsies and cystoscopies. The Chief of Surgery sent the urologist an email acknowledging the request and stating the request would be granted. Notably, the Chief of Surgery did not have the authority to approve the request. The Chief of Surgery's response also noted that paperwork needed to be completed to make the change "official." According to the Coordinator, the urologist's privileges were not voluntarily reduced.

Acting COS Attempt to Reduce Privileges

VHA policy does not permit the COS to unilaterally reduce a provider's privileges for cause.[48]

The OIG determined that despite the Acting COS deciding to reduce the urologist's privileges, the privileges were not reduced based on this decision.

The Chief of Surgery sent the Acting COS the proctor's report and proposed next steps, including removing open cases from the urologist's caseload. The Acting COS received guidance regarding the urologist's request to reduce privileges from the VHA Director of Medical Staff Affairs. The Facility Director advised the Acting COS to not allow a voluntary

[47] VHA Handbook 1100.19. "VetPro is an Internet enabled data bank for the credentialing of VHA health care practitioners that facilitates completion of a uniform, accurate, and complete credentials file." The process for voluntary reduction of privileges includes an MEC recommendation and facility director decision.
[48] VHA Handbook 1100.19.

reduction of privileges, but to await the results of the FPPE for cause and clinical review. During an OIG interview, the Acting COS reported deciding to deny the urologist's request to voluntarily reduce privileges since there were "patient concern issues."

Without the benefit of a formal evaluation of the suspected physical impairment, the Acting COS reported reviewing the urologist's privileges and operating schedule with the Chief of Surgery to identify procedures that could be safely performed. The Acting COS informed the Chief of Surgery that the urologist's privileges to perform open surgical procedures were to be removed immediately and that new privileges would need to be presented to the Facility Director. The Acting COS also informed the Chief of Surgery that credentialing and privileging staff would issue "the standard forms and memoranda."

During the MEC meeting in December 2018, when the FPPE for cause was presented, the proctor assigned to oversee the FPPE for cause recommended that the urologist no longer have privileges for surgical cases requiring incisions. The Acting COS mistakenly reported that the urologist's privileges had already been reduced due to cause. However, according to the Coordinator, the urologist's privileges had not been modified. Notably, the MEC membership did not recognize that a reduction in privileges for cause required a recommendation by the MEC and approval by the facility director.

MEC Reduction in Privileges

VHA policy empowers the MEC to recommend that the facility director reduce privileges based upon "review and deliberation of clinical performance and professional conduct information."[49] Prior to a reduction in privileges due to performance or conduct issues, the practitioner must receive notification of the proposed reduction, the reason for the proposal, and procedural due process rights including the ability to respond to the proposal. Physicians and dentists must be informed of the possibility of being reported to the National Practitioners Data Bank and state licensing boards.[50] The final decision to reduce privileges must be made on the basis of the record and documented by the facility director. The process for non-voluntary reduction of privileges is shown in figure 3.

[49] VHA Handbook 1100.19.

[50] VHA Handbook 1100.19.

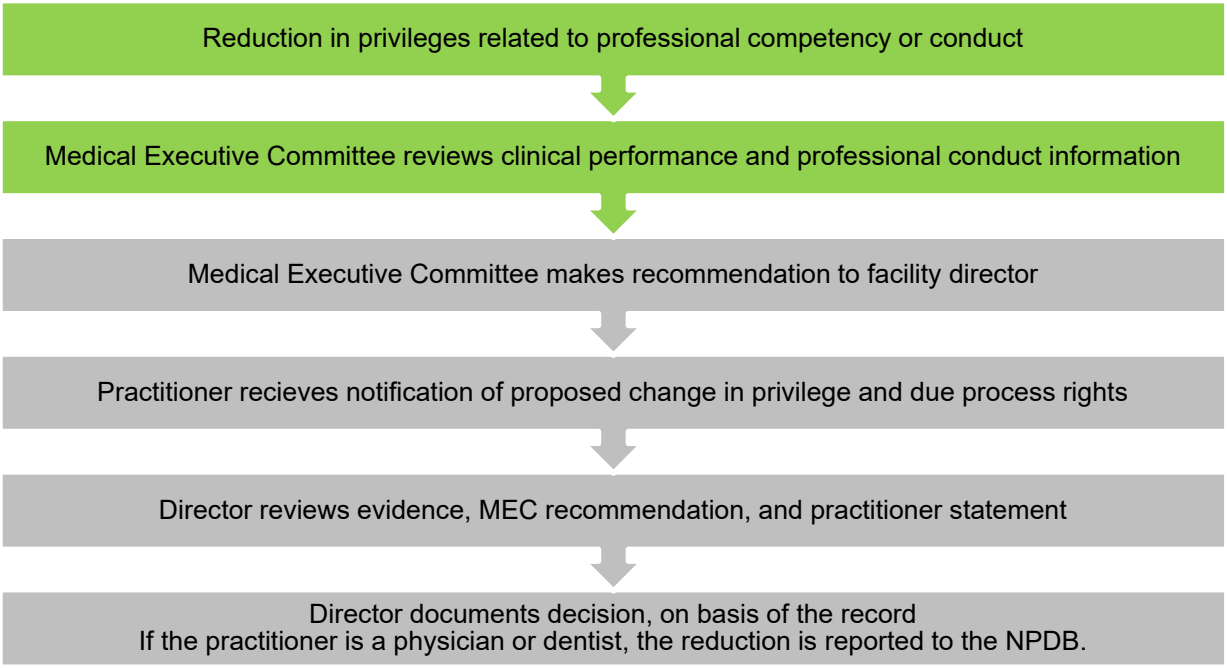

Figure 3: VHA's Process for Non-Voluntary Reduction of Privileges[51]
Source: OIG review VHA Handbook 1100.19
Note: Green denotes MEC compliance with the step in the process; gray denotes noncompliance.

The OIG found that in February 2019, during routine biennial reprivileging, the urologist's privileges were reduced without following mandatory procedures for reducing privileges.

The OIG reviewed VetPro documentation to support the urologist's reprivileging application for the period covering February 2019 to February 2021. The VetPro documentation included statements that the urologist had hand tremors. The Coordinator reported being aware of the statements regarding tremors and that the statements should have led credentialing and privileging staff to question whether the urologist required a physical examination. The Coordinator acknowledged that credentialing and privileging staff did not ask the question. The Coordinator, who at the time of the OIG inspection had been in the position for less than a year, reported continuing to learn the position.

The OIG also reviewed the urologist's reprivileging application. The urologist's request included privileges to perform open surgical cases that required incisions. The request form showed that the Acting Chief of Surgery recommended denial of the requested privileges to perform open procedures. The MEC concurred with the Acting Chief of Surgery's recommendation, and the Facility Director approved the denial of the open procedure privileging request, thus reducing the urologist's privileges.

[51] VHA Handbook 1100.19. The process for non-voluntary reduction of privileges includes MEC recommendation, practitioner notification and facility director decision.

MEC minutes from the meeting during which the urologist was reprivileged reported that the committee discussed the urologist's VetPro documentation. The Coordinator informed the OIG that the VetPro documentation, including statements about tremors, was displayed on screens during the meeting to permit visualization by participants. Although the MEC ultimately recommended the denial of open procedure privileges for the urologist, neither the privileging documentation nor the MEC minutes indicated the reason for the decrease in privileges.

Notably, the OIG received no documentation to indicate that the facility notified the urologist of the privilege changes, the right to make a statement, or the possibility of being reported to the National Practitioners Data Bank and state licensing boards. During an OIG interview, after being asked about the result of the February 2019 privileging, the urologist stated "[m]y privileges haven't changed as far as I know."

The OIG found that facility leaders failed to inform the urologist that the request to voluntarily reduce privileges was denied. This led to the urologist believing, mistakenly, that the request had been granted and that privileges were reduced. The Acting COS's misstatement to the MEC that the urologist's privileges had been reduced led to the MEC not making a recommendation regarding the urologist's privileges. Although the urologist and Acting COS intended to reduce privileges in 2018, the reduction did not occur. Therefore, according to the urologist's privileging file, the urologist was permitted to continue to perform open procedures.[52] During the February 2019 MEC meeting, when the urologist's privileges were reduced to procedures that did not require an incision, the MEC's recommendation was not based on a formal evaluation of the urologist's unconfirmed physical impairment, failed to comply with VHA notification requirements, and failed to indicate the reason for the reduction.

4. Failure to Comply with National Practitioners Data Bank and State Licensing Board Reporting Directives

The OIG determined that facility leaders did not adhere to VHA directives regarding reporting safety concerns to the National Practitioners Data Bank and state licensing boards related to the urologist's professional practice.

National Practitioners Data Bank Reporting

National Practitioners Data Bank goals include "improving health care quality, [and] protecting the public."[53] VHA requires reporting to the National Practitioners Data Bank any physician or dentist for a final adverse privileging action based on professional conduct or performance that

[52] The urologist only completed non-open procedures after the October 2018 request to reduce full privileges was made.
[53] U.S. Department of Health and Human Services, Health Resources and Services Administration. *NPDB Guidebook.* Rockville, Maryland: U.S. Department of Health and Human Services, 2018.

lasts longer than 30 days (for example, restriction, suspension, revocation).[54] Additionally, physicians and dentists who resign or reduce privileges during an investigation related to professional conduct or competence must be reported. National Practitioners Data Bank reporting may only occur after the practitioner's due process rights are exhausted.[55] A copy of a National Practitioners Data Bank report must also be sent to the licensing boards of the state in which the VA facility is located, as well as any state in which the practitioner holds a license to practice.[56]

The Coordinator confirmed that the Facility Director did not report the urologist to the National Practitioners Data Bank for the reduction in privileges action that occurred in February 2019. The Coordinator mistakenly informed the OIG that the reduction in privileges was not a reportable event. The Coordinator also described that the privileges were voluntarily reduced by the urologist and was apparently not aware that the Acting COS had decided not to permit a voluntary reduction. Notably, the procedures used to reduce the urologist's privileges did not include a notification of the contemplated adverse action, due process rights, or National Practitioners Data Bank reporting requirements.

In November 2019, the OIG CHIP team recommended that the Facility Director report privileging actions to the National Practitioners Data Bank. Therefore, an additional recommendation regarding reporting adverse privileging actions to the National Practitioners Data Bank was not made in this report.[57]

State Licensing Board Reporting

VHA requires facility directors to report any licensed healthcare practitioner whose clinical practice or behavior "so substantially failed to meet generally-accepted standards of clinical practice as to raise a reasonable concern for the safety of patients" to their respective state licensing board.[58] According to VHA policy, a "[p]hysical health impairment sufficient to cause the individual to provide unsafe patient care" is an example of an issue that "would ordinarily provide a reasonable basis for a concern for the safety of patients, and as such, would be reported."[59] Facility directors must initiate a state licensing board review within seven calendar days of receipt of information that suggests a practitioner's clinical practice may have met the

[54] VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009. "For the purpose of NPDB reporting, adverse action is defined as reduction, suspension, denial (other than initial), nonrenewal, or revocation of privileges for a period exceeding 30 calendar days."

[55] VHA Handbook 1100.17.

[56] VHA Handbook 1100.17.

[57] Department of Veterans Affairs Office of Inspector General, *Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center, Dublin, Georgia*.

[58] VHA Handbook 1100.18, *Reporting to State Licensing Boards*, December 22, 2005, amended February 5, 2018.

[59] VHA Handbook 1100.18.

reporting standard.[60] The initiation of the state licensing board review, which includes notifying the practitioner, is mandatory.[61] The decision to report the practitioner to the state licensing board, however, is at the discretion of the facility director.[62]

The OIG did not establish the earliest date the Acting Facility Director was informed of the patient safety concern. However, on November 7, 2018, when the Acting Facility Director signed the summary suspension letter that described the urologist's practice as a potential imminent threat to patient welfare, the Acting Facility Director was required to initiate a state licensing board review. According to the Coordinator, a state licensing board review was not initiated due to being inexperienced with the reporting processes and also due to being informed by the Acting COS "that the situation was taken care of." On May 13, 2020, the Coordinator informed the OIG that the urologist was being reported to the state licensing board.

The OIG found, as a result of noncompliance with reporting directives, patient safety concerns for the urologist's performance were not communicated to the National Practitioners Data Bank and not timely communicated to the state licensing board. Therefore, patient safeguards intended to be achieved through reporting did not occur.

5. Facility Leader Changes

The OIG found that frequent changes in the facility director, chief of staff, and chief of surgery positions may have contributed to the deficiencies with the oversight, privileging, and reporting processes used for the urologist.

The facility director is ultimately responsible for making privileging decisions as well as reporting practitioners to the National Practitioners Data Bank and state licensing boards. The chief of staff plays a pivotal role in several patient safety activities, including chairing the MEC, ordering clinical reviews, and recommending suspension of privileges. The service chief (for example, the chief of surgery) is responsible for oversight of practitioners' professional competency and performance, and making privileging recommendations to the MEC.

Since October 2017, the facility director and chief of staff positions were filled with several interim and acting staff. As figure 4 illustrates, frequent changes in these key positions occurred during the oversight and privileging of the urologist.

[60] VHA Handbook 1100.18.

[61] VHA Handbook 1100.18.

[62] VHA Handbook 1100.18.

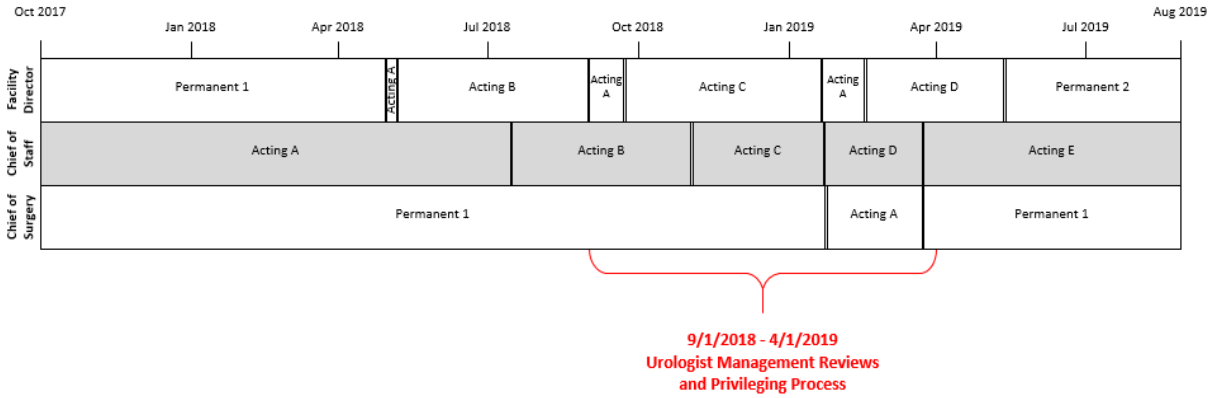

Figure 4. Changes in Three Key Leadership Positions at the Facility October 2017–August 28, 2019 [63]
Source: Facility documents and interviews regarding facility leaders' periods of appointment

A facility director vacated the position on April 14, 2018. There were six periods during which an acting or interim director filled the position until a permanent facility director entered the role on May 13, 2019. The COS position was filled by five acting COS during the period October 2017 through August 28, 2019. The chief of surgery position was primarily filled with a permanent chief of surgery from October 1, 2017, to August 28, 2019; however, this individual served as the acting COS from January 23, 2019, to March 23, 2019. During that time, another surgeon served as acting chief of surgery. Notably, during the September 2018 through April 2019 time frame when the oversight, privileging, and reporting failures occurred, the facility experienced five separate instances of acting facility directors, had four different acting COS and a permanent and an acting chief of surgery.

The Chief of Surgery explained to the OIG that the frequent changes in leadership may have led to not being informed of the summary suspension letter or the clinical care review being completed. Without being informed of the suspension or evaluations, the Chief of Surgery would not have been able to enact the suspension or utilize information from the review. The Acting COS who held the position in spring 2019, the time when the urologist was placed on an ongoing professional practice evaluation, reported not being familiar with the details of the urologist's recent privileging processes or evaluations. During an OIG interview, this Acting COS acknowledged that turnover and knowledge deficits contributed to evaluations not being completed. Further exacerbating the impact of frequent leader turnover, the OIG learned during interviews that support staff did not have proficiency in managing complex medical staff issues such as clinical care reviews, reduction in privilege processes, or mandated compliance with VHA reporting directives.

[63] During the period September 1, 2018 to April 1, 2019, five acting facility directors included two instances of Acting Facility Director A and one instance of Acting Facility Director B, C, and D.

Frequent leader changes may have contributed to the shortcomings with facility leaders' oversight, privileging, and reporting processes. The leaders' noncompliance with facility and VHA policies may have occurred due to an incomplete exchange of information, a lack of knowledge of position responsibilities, and inexperienced support staff.

Conclusion

Facility leaders and staff identified, managed, reported, and acted upon the two adverse clinical outcomes. The OIG did not identify unreported adverse clinical outcomes related to the urologist's practice.

Facility leaders did not conduct a formal evaluation for physical impairments in response to a report that the urologist had severe hand tremors and possibly low visual acuity that may have impacted patient safety.

Deficiencies with facility leaders' oversight of the urologist were identified by the OIG in the FPPE for cause, the standard FPPE, and clinical care review processes. Specifically, the FPPE forms did not indicate the specific clinical concerns or customized performance indicators. Additionally, the closure of the FPPE for cause was based, in part, on the Acting COS's inaccurate statement that the urologist's privileges had already been reduced for cause. Facility leaders did not complete the FPPE form that documented the evaluation that was closed in February 2019 and did not indicate that competencies were met. The Facility Director implemented an improvement plan to address a 2019 CHIP recommendation to remediate deficiencies in the initiation, documentation, and utilization of FPPEs. Therefore, the OIG did not make a recommendation to address FPPE deficiencies in this report.

Facility leaders did not initiate the clinical care review with instructions for completing the review, and the Chief of Surgery, COS, and MEC did not review or discuss the results. Furthermore, facility staff did not ensure the urologist received the letter with the notification of the suspension of open procedure privileges pending the review results. The Chief of Surgery reported not knowing about the summary suspension or the clinical care review results.

The urologist and Acting COS did not complete attempts to reduce the urologist's privileges. Therefore, the urologist maintained privileges to perform open procedures until four months later when the MEC recommended, and the Facility Director approved, the reduction in privileges. Facility leaders did not comply with VHA procedures for reducing privileges by failing to notify the urologist of the proposed change, the ability to make a statement, or the possibility of being reported to the National Practitioners Data Bank and the state licensing board.

Facility leaders failed to comply with National Practitioners Data Bank and state licensing board reporting directives. Specifically, an adverse privileging action that affected the urologist's privileges for more than 30 days required a report to the National Practitioners Data Bank. The concern that the urologist's practice may be an imminent threat to patient welfare required, at a

minimum, a state licensing board review. In response to a 2019 CHIP recommendation, the Facility Director implemented an improvement plan to ensure that adverse privileging actions were reported to the National Practitioners Data Bank. Therefore, the OIG did not make a recommendation regarding National Practitioners Data Bank reporting in this report.

Multiple changes of the facility's Director and COS, as well as a brief change in the Chief of Surgery position, may have contributed to the facility leaders' failures to comply with VHA policies regarding oversight, privileging, and reporting processes.

Recommendations 1–6

1. The Veterans Integrated Service Network 7 Director ensures Carl Vinson VA Medical Center leaders, in permanent or acting roles, are knowledgeable about and compliant with the oversight of medical staff, including those with possible physical impairments.
2. The Veterans Integrated Service Network 7 Director ensures Carl Vinson VA Medical Center leaders, in permanent or acting roles, are knowledgeable about and compliant with privileging policies.
3. The Veterans Integrated Service Network 7 Director ensures Carl Vinson VA Medical Center leaders, in permanent or acting roles, are knowledgeable about and compliant with state licensing board reporting policies.
4. The Carl Vinson VA Medical Center Director evaluates concerns that the urologist has a possible physical impairment, consults with Human Resources, and takes action, if indicated.
5. The Carl Vinson VA Medical Center Director reviews current clinical care review processes, identifies areas of noncompliance with facility bylaws, and takes action to ensure compliance.
6. The Carl Vinson VA Medical Center Director reviews current reduction of privileges processes, identifies areas of noncompliance, and takes action to ensure compliance with Veterans Health Administration policy.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: August 26, 2020

From: Director, VA Southeast Network (VISN 10N7)

Subj: Draft Report: Healthcare Inspection—Deficiencies in Provider Oversight and Privileging Processes at the Carl Vinson VA Medical Center in Dublin, Georgia

To: Director, Office of Healthcare Inspections (54HL04)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. I have had the opportunity to review the Draft Report: Healthcare Inspection—Deficiencies in Provider Oversight and Privileging Processes at the Carl Vinson VA Medical Center in Dublin, Georgia.

2. VISN 7 submits the attached action plan for recommendations 1-3, and concurrence to the Carl Vinson Medical Center action plan for recommendations 4-6.

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

4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(Original signed by:)

Joe D. Battle
Interim Director, VA Southeast Network (VISN 7) (10N7)

VISN Director Response

Recommendation 1

The Veterans Integrated Service Network 7 Director ensures Carl Vinson VA Medical Center leaders, in permanent or acting roles, are knowledgeable about and compliant with the oversight of medical staff, including those with possible physical impairments.

Concur.

Target date for completion: The Chief Medical Officer, Deputy Chief Medical Officer and VISN 7 Risk Manager completed a virtual site review on 8/17/2020. The review included oversight of medical staff with possible physical impairments. Site reviews will be completed annually and more frequently if there are changes in leadership.

Director Comments

In December, 2019, Carl Vinson VA Medical Center leaders in permanent or acting roles were required to appoint a multidisciplinary team to complete the annual Credentialing and Privileging Program self-assessment to confirm full compliance with the requirements of VHA Handbook 1100.19 Credentialing and Privileging and VHA Directive 2012-030, Credentialing of Health Care Professionals. This annual self-assessment was completed using an auditing tool created by the VA Office of Medical Staff Affairs and was designed to identify areas of excellence as well as challenges in areas such as licensure, credentialing, privileging, adverse actions, Medical Staff, and Ongoing Professional Practice Evaluation/Focused Professional Practice Evaluation. On January 8, 2020 the self-assessment team received training by the Deputy Director, Medical Staff Affairs as well as follow-up conference call with the VISN to identify potential barriers in the process. The completed self- assessment required attestations from each member of the leadership team including the Director, Chief of Staff, Associate Director for Patient Care Service, Associate Director, and Chief, Human Resources. The self-assessment was submitted to the Office of Medical Staff Affairs on January 30, 2020 for review and analysis. On June 15, 2020, the Deputy Director, Medical Staff Affairs met with the Acting Chief Medical Office/Deputy Chief Medical Officer and VISN POC [point of contact] to review the results of the VISN7 medical centers self-assessments. The information shared included guidance for the required Chief Medical Officer annual site reviews to ensure follow-up and closure of action plans for 100% compliance.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 2

The Veterans Integrated Service Network 7 Director ensures Carl Vinson VA Medical Center leaders, in permanent or acting roles, are knowledgeable about and compliant with privileging policies.

Concur.

Target date for completion: The Chief Medical Officer, Deputy Chief Medical Officer and VISN 7 Risk Manager completed a virtual site review on 8/17/2020. The review included an assessment of knowledge about and compliance with privileging policies. Site reviews will be completed annually and more frequently if there are changes in leadership.

Director Comments

The Chief Medical Officer's initial and annual site reviews include assessment of knowledge about and compliance with privileging policies. The Carl Vinson VA had an initial site review conducted by the Acting Chief Medical Officer of VISN 7 in November 2019. In addition, the Carl Vinson VA Medical Center leaders in permanent or acting roles are required to attest to the annual Credentialing and Privileging Program self-assessment. This self-assessment confirms full compliance with the requirements of VHA Handbook 1100.19 Credentialing and Privileging; VHA Handbook 1100.17 National Practitioner Data Bank Reports (NPDB); VHA 1100.18 Reporting and Responding to State Licensing Boards; and VHA Directive 2012-030, Credentialing of Health Care Professionals. The annual self- assessment uses an auditing tool created by the VA Office of Medical Staff Affairs and is designed to identify areas of excellence as well as challenges in areas such as licensure, credentialing, privileging, adverse actions, Medical Staff and Focused Professional Practice Evaluation/Ongoing Professional Practice Evaluation.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 3

The Veterans Integrated Service Network 7 Director ensures Carl Vinson VA Medical Center leaders, in permanent or acting roles, are knowledgeable about and compliant with state licensing board reporting policies.

Concur.

Target date for completion: The Chief Medical Officer, Deputy Chief Medical Officer and VISN 7 Risk Manager completed a virtual site review on 8/17/2020.

Director Comments

The Chief Medical Officer's initial site review in November 2019 and annual site reviews will include assessment of knowledge about and compliance with state licensing board reporting policies. In addition, the Carl Vinson VA Medical Center leaders in permanent or acting roles are required to attest to the accuracy of the annual Credentialing and Privileging Program self-assessment. This self-assessment confirms full compliance with the requirements of VHA Handbook 1100.19 Credentialing and Privileging; VHA Handbook 1100.17 National Practitioner Data Bank Reports (NPDB); VHA 1100.18 Reporting and Responding to State Licensing Boards; and VHA Directive 2012-030, Credentialing of Health Care Professionals. The annual self-assessment uses an auditing tool created by the VA Office of Medical Staff Affairs and is designed to identify areas of excellence as well as challenges in areas such as licensure, credentialing, privileging, adverse actions, Medical Staff and Focused Professional Practice Evaluation/Ongoing Professional Practice Evaluation.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: August 12, 2020

From: Director, Carl Vinson VA Medical Center (557)

Subj: Concurrence Memo—Healthcare Inspection—Deficiencies in Provider Oversight and Privileging Processes at the Carl Vinson VA Medical Center in Dublin, Georgia

To: Director, VA Southeast Network (VISN 10N7)

1. I have had the opportunity to review the Healthcare Inspection—Deficiencies in Provider Oversight and Privileging Processes at the Carl Vinson VA Medical Center in Dublin, Georgia.
2. Carl Vinson VA Medical Center submits the attached action plan for recommendations 4-6.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the Quality Management Officer.

(Original signed by:)

David L. Whitmer, FACHE
Director, Carl Vinson VA Medical Center (557)

Facility Director Response

Recommendation 4

The Carl Vinson VA Medical Center Director evaluates concerns that the urologist has a possible physical impairment, consults with Human Resources, and takes action, if indicated.

Concur.

Target date for completion: Complete

Director Comments

The Carl Vinson VA Medical Center Director evaluated concerns that the urologist has a possible physical impairment, consulted with Human Resources, and took action, as indicated. The Medical Executive Committee reviewed and addressed the Urologist privileges after a Focused Professional Peer Evaluation.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 5

The Carl Vinson VA Medical Center Director reviews current clinical care review processes, identifies areas of noncompliance with Medical Center Bylaws & Medical Staff Rules, and takes action to ensure compliance.

Concur.

Target date for completion: September 30, 2020

Director Comments

Clinical care review processes reviewed. An audit of Service Line Chiefs' training completed August 11, 2020. Service Line Chiefs who are noncompliant will complete the appropriate training. The Chief of Staff and all Clinical Service Line Chiefs will be advised of and educated on the process. Any new, Interim, or Acting Chief will complete training during their first week of accepting the position.

Quality Management will monitor and report to Chief of Staff and Medical Center Director.

Recommendation 6

The Carl Vinson VA Medical Center Director reviews current reduction of privileges processes, identifies areas of noncompliance, and takes action to ensure compliance with Veterans Health Administration policy.

Concur.

Target date for completion: September 1, 2020

Director Comments

The privileging process were reviewed. The Provider Competency and Clinical Concerns including Focused Clinical Care Review and FPPE for Cause Guidance obtained from the Medical Staff Affairs Credentialing intranet will be used to guide all clinical concerns. The Chief of Staff and all Clinical Service Line Chiefs will be advised of and educated the process. Any new, Interim, or Acting Chief will complete training during their first week of accepting the position.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

OIG Contact and Staff Acknowledgments

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