

VA



U.S. Department
of Veterans Affairs

U.S. OFFICE OF
SPECIAL COUNSEL
WASHINGTON, D.C.

Office of the General Counsel
Washington DC 20420

2013 AUG 15 PM 2:02

AUG 15 2013

In Reply Refer To:

The Honorable Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M. Street, NW, Suite 300
Washington, DC 20036-4505

RE: OSC File Nos. DI-13-2644

Dear Ms. Lerner:

Enclosed are the redacted and unredacted reports as described in the letter signed by VA Chief of Staff Jose D. Riojas. The Chief of Staff was delegated by Secretary Shinseki to sign the report. We hereby request that your office publish the enclosed redacted version. VA's unredacted response identifies the individuals who were interviewed during the investigation, or who conducted the investigation, by names and job titles.

If you have any questions about this request, please contact Jennifer Gray in the Office of General Counsel at 202-461-7634.

Sincerely,

A handwritten signature in black ink, appearing to read "Walter A. Hall".

Walter A. Hall
Assistant General Counsel

Enclosures



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

August 13, 2013

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-13-2644

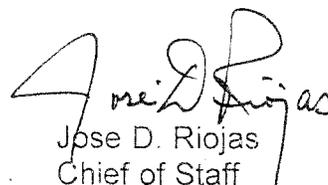
Dear Ms. Lerner:

I am responding to your letter regarding the Department of Veterans Affairs (VA) G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi (hereafter, the Medical Center), where an anonymous whistleblower alleged that by relying on credentialing and privileging (C&P) processes not in accordance with agency-wide and local policies, the leadership engaged in conduct that may constitute a violation of laws, rules, or regulations, an abuse of authority, and a substantial and specific danger to public health. The whistleblower also alleged that these C&P processes bypassed the Executive Committee charged with submitting recommendations to the Medical Center Director, that relevant information had been withheld from this Committee, that this Committee's votes had been falsely documented, and that the preceding activities led to the improper reprivileging of at least one physician. The Secretary has delegated to me the authority to sign this report and take any actions deemed necessary under 5 U.S.C. § 1213(d)(5).

The Secretary also asked the Under Secretary for Health to review this matter and to take any actions deemed necessary under 5 U.S.C. § 1213(d)(5). He, in turn, directed the Office of the Medical Inspector (OMI) to conduct an investigation. In its investigation, OMI substantiated three of the whistleblower's four allegations, confirming that the Medical Center's C&P practices were incorrect, that information had been withheld, and that false documentation had taken place, but did not substantiate the fourth – that these practices resulted in improper privileging of providers. OMI made three recommendations to the facility for improving its C&P processes. Findings from OMI's investigation are contained in the enclosed Final Report, which I am submitting for your review.

Thank you for the opportunity to respond to this issue.

Sincerely,


Jose D. Riojas
Chief of Staff

Enclosure

OFFICE OF THE MEDICAL INSPECTOR

**Report to the
Office of Special Counsel
OSC File Number DI-13-2644**

**Department of Veterans Affairs
G.V. (Sonny) Montgomery VA Medical Center
Jackson, Mississippi**



**Veterans Health Administration
Washington, DC**

**Report Date: July 12, 2013
2013-D-653**

Any information in this report that is the subject of the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty provisions of those statutes.

Executive Summary

Summary of Allegations

The Under Secretary for Health (USH) requested that the Office of the Medical Inspector (OMI) investigate complaints lodged with the Office of Special Counsel (OSC) by a Department of Veterans Affairs' (VA) employee (hereafter, the whistleblower) at the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi (hereafter, the Medical Center). The anonymous whistleblower alleged that by relying on credentialing and privileging processes that were not in accordance with agency-wide and local facility policies, the Medical Center may have violated laws, rules, or regulations, engaged in gross mismanagement and an abuse of authority, and created a substantial and specific danger to public health and safety. OMI conducted a site visit to the Medical Center on June 5-6, 2013.

The whistleblower's allegations are as follows:

1. The Medical Center employed incorrect credentialing and privileging processes that have led to the improper re-privileging of at least one physician in violation of agency policy.
2. Information including names, malpractice history, and disciplinary history about physicians who apply for credentialing or privileging is not being provided, as required by agency policy, to the Medical Center Clinical Executive Board (CEB) for its decision-making process.
3. CEB votes on credentialing and privileging were regularly and falsely reported as having been taken in meeting minutes of the Medical Center's Professional Standards Board (PSB).
4. These improper privileging and credentialing practices may have resulted in the incorrect privileging of additional practitioners.

Conclusions

1. OMI substantiates the allegation that the Medical Center relied upon incorrect credentialing and privileging processes that were technically noncompliant with Veterans Health Administration (VHA) policy and contrary to Medical Center Bylaws governing credentialing and privileging. VHA policy stipulates that the Executive Committee of the Medical Staff (in the Medical Center, the CEB) is the body charged with making credentialing and privileging recommendations to the facility Director. Although the Medical Center Director approved privileging and re-privileging requests before receiving the recommendation of the CEB, he approved them after a detailed consideration of the requests and recommendations by the PSB, another committee comprised of executive members of the Medical Center medical staff.

Therefore, the Medical Center ensured oversight of the credentialing and privileging of medical staff members, but it was provided by the limited membership of the PSB, not by the full membership of the CEB, as required by the Medical Center Bylaws and policy. Although technically noncompliant with VHA policy, OMI believes the Medical Center did comply with the intent of the VHA policy requiring medical staff oversight of the credentialing and privileging of medical staff members (see conclusion 4 below).

2. OMI substantiates the allegation that the Medical Center was not providing sufficient information to the CEB for them to come to an informed recommendation about an applicant's credentials and requested privileges. In some instances, names were not provided; in other instances, names with only a short summary of the applicant's credentials were provided. In all instances, the voting members of the CEB did not have access to the minutes and the discussions of the PSB meetings on individual applicants. It appears the CEB was actually voting after the Director had already approved the privileges.
3. OMI substantiates the allegation that the electronic voting by the CEB on credentialing and privileging was incorrectly reported in PSB meeting minutes as having taken place. We found that privileging requests of physicians were reviewed by the PSB and submitted to the Medical Center Director for approval before the CEB voted. Although there was oversight mismanagement of the credentialing and privileging process and misstatements of facts, OMI found no evidence that there was intent to deceive by anyone on the PSB.
4. OMI does not substantiate the allegation that the Medical Center's improper credentialing and privileging practices may have resulted in incorrect privileging of providers. Although Medical Center leadership did not follow the privileging process outlined in its bylaws and local policy, there is overwhelming evidence in the two examples cited by the whistleblower that the Director, Chief of Staff, and other clinical leaders were intimately involved with those privileging actions. In the first example, Medical Center leadership went to great lengths to ensure the practice of the ophthalmologist was completely evaluated before, and closely monitored after, his return to clinical practice, even if this evaluation and monitoring took place within the structure of the PSB rather than the CEB. In the second example, the PSB reviewed the malpractice claims against the ophthalmologist and made appropriate privileging recommendations to the Director.
5. The electronic voting system utilized by the Medical Center is not described or mentioned in either the VHA Handbook or the Medical Center Bylaws or policies on the credentialing and privileging process.
6. OMI concludes that the Director's practice of not dating his signature on PSB meeting minutes made it difficult to validate the sequencing or timeliness of the Medical Center's credentialing and privileging process.

Recommendations

1. The Medical Center should revise its credentialing and privileging process to ensure that CEB members all have equal access to the individual applicant's credentials, and to the minutes of the PSB meetings, prior to the Director's approval. The future process must be compliant with VHA policy, Medical Center Bylaws, and local policy.
2. The Medical Center should review the utilization and effectiveness of their electronic voting system within the privileging process and if retained, develop a policy that clearly describes the purpose and operation of this system.
3. The Medical Center should ensure that all signatures by the Director on privileging documents are dated.

Summary Statement

OMI's investigation did not find violations or apparent violations of statutory laws or mandatory rules or regulations as set forth in the Code of Federal Regulations. OMI did not find evidence of abuse of authority. OMI did not find evidence of a substantial and specific danger to the public health and safety at the Medical Center. However, OMI found the Medical Center technically noncompliant with VHA Handbook 1100.19, *Credentialing and Privileging*, and noncompliant with its own Medical Center Bylaws. OMI believes there was mismanagement in the administration of the credentialing and privileging processes.

I. Introduction

The Under Secretary for Health (USH) requested that the Office of the Medical Inspector (OMI) investigate complaints lodged with the Office of Special Counsel (OSC) by a Department of Veterans Affairs' (VA) employee (hereafter, the whistleblower) at the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi (hereafter, the Medical Center). The anonymous whistleblower alleged that by relying on credentialing and privileging processes that were not in accordance with agency-wide and local facility policies, the Medical Center may have violated laws, rules, or regulations, engaged in gross mismanagement and an abuse of authority, and created a substantial and specific danger to public health and safety. OMI conducted a site visit to the Medical Center on June 5-6, 2013.

II. Facility Profile

The Medical Center, part of Veterans Integrated Service Network (VISN) 16, consists of the main facility in Jackson, with 128 inpatient beds for general medicine, surgery, neurology, and mental health services, and seven community-based outpatient clinics. Special programs include treatment of cancer, spinal cord injury, Post-traumatic Stress Disorder, substance abuse, sleep studies, and dual diagnosis. The Medical Center is affiliated with the University of Mississippi and trains resident physicians in internal medicine and other specialty areas.

III. Allegations

The whistleblower's allegations are as follows:

1. The Medical Center employed incorrect credentialing and privileging processes that have led to the improper re-privileging of at least one physician in violation of agency policy.
2. Information including names, malpractice history, and disciplinary history about physicians who apply for credentialing or privileging is not being provided, as required by agency policy, to the Medical Center Clinical Executive Board (CEB) for its decision-making process.
3. CEB votes on credentialing and privileging were regularly and falsely reported as having been taken in meeting minutes of the Medical Center's Professional Standards Board (PSB).
4. These improper privileging and credentialing practices may have resulted in the incorrect privileging of additional practitioners.

IV. Conduct of Investigation

An OMI team consisting of Edward Huycke, M.D., the Deputy Medical Inspector for National Assessments; Bernard Winkel, Ed.D., Clinical Psychologist, both from OMI, and Kathryn Enchelmayer, MS, MHSA, Director, Credentialing and Privileging for the Veterans Health Administration (VHA), conducted the site visit. OMI reviewed relevant policies, procedures, reports, memorandums, and other documents (a complete list of which is in Attachment A) and held an entrance and an exit briefing with Medical Center leadership including Joe Battle, Medical Center Director; Dr. Olawale O. Fashina, Acting Chief of Staff (COS); LaWanda Parks, Assistant Director; Salena Wright-Brown, Acting Associate Director of Patient Care Services; and Dr. Jessie Spencer, Chief of Medicine, who had recently served as interim COS.

OMI interviewed the following individuals:

Joe D. Battle, Medical Center Director;

Darren Travis, Executive Assistant, COS;

Dr. Kent Kirchner, Nephrologist (former COS);

Dr. Jessie Spencer, Chief of Medicine (former interim COS);

Dr. Roy Reeves, Chief of Psychiatry;

Dr. Elizabeth Cary, Acting Chief of Pathology and Laboratory Service;

Dr. Eric Undesser, Chief of Neurology;

Dr. Ronald Braswell, Acting Chief of Surgery and Chief of Ophthalmology;

Dr. Richard Snyder, President of the Medical Staff;

Dr. Michael Palmer, elected Medical Staff Representative and at-large member of the CEB;

Dr. Roxanne Bahudur, elected Medical Staff Representative and at-large member of the CEB;

Dr. Andre Burnett, elected Medical Staff Representative and at-large member of the CEB;

Dr. Daniel Kim, staff ophthalmologist;

Charlene Taylor, Credentialing Coordinator;

Jennifer Sayles, secretary to the COS; and

Dr. Gregg Parker, Chief Medical Officer (CMO) VISN 16.

The Office of General Counsel reviewed OMI's findings to determine whether there was any violation of law, rule, or regulation.

OMI **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. OMI **did not substantiate** allegations when the facts showed the allegations were unfounded. OMI **could not substantiate** allegations when we found no conclusive evidence either to sustain or refute the allegations.

V. Findings

VHA Handbook 1100.19, *Credentialing and Privileging*, defines the policy for credentialing and privileging VA providers. Credentialing involves the verification of the individual's professional education; training; licensure; certification and health status; previous experience, including gaps in employment; clinical privileges; professional references; malpractice history and adverse actions; or criminal violations. The credentialing process ensures that each new applicant for appointment to the medical staff meets the requirements for the position and is entitled to the requested privileges.

Clinical privileging is the process by which the facility grants the applicant permission to independently provide specified patient care services within the scope of the applicant's license and clinical competence, and within the facility's capabilities. Clinical privileges are granted for no longer than 2 years, after which they must be reappraised and regranted. For providers who already hold clinical privileges within the facility, reappraisal of their credentials includes: the provider's statement about successful or pending challenges to licensure or registration; voluntary or involuntary relinquishment of licensure or registration; limitation, reduction, or loss of privileges at another hospital; loss of medical staff membership; pending malpractice claims or claims closed since the provider's last reappraisal; mental and physical status; and any other reasonable indicators of continuing qualification and competency.

VHA Handbook 1100.19 specifies that consideration of a provider's credentials and application for privileges, both at the initial appointment and on reappraisal, starts with the service chief's review, followed by a recommendation to the credentialing committee and the Medical Staff's Executive Committee. The Executive Committee recommends to the governing body (in VHA facilities, the Medical Center Director) to grant or deny the applicant or reapplicant's clinical privileges. Upon approval of the Executive Committee's recommendations, the Director informs the applicant or reapplicant, by letter, of the privileges granted.

Under the Medical Center Bylaws and rules of the medical staff, adopted December 18, 2009, the CEB functions as an authorized Executive Committee of the medical staff. The PSB functions as the credentialing committee.

The Medical Center defines its procedures for reviewing credentials and granting privileges in *Credentialing and Privileging of Independent Practitioners*, Medical Center Policy No. K-11-P-60 (December 31, 2012). The service chief reviews the applicant's or

reapplicant's credentials. In the case of reapplicants, this involves the practitioner's performance, judgment, clinical or technical competence, skills, an evaluation of physical and mental status, and current privileges. This policy states that the service chief's recommendation be reviewed by the PSB and then be submitted to the CEB.

The CEB is chaired by the COS and composed of 12 additional voting members: the President of the medical staff, the Service Chiefs of medicine, surgery, neurology, and mental health, the Chief of the Dental Service, the Chief of the Psychology Service, the Chief of the Pathology and Laboratory Medicine Service, and 4 at-large members elected to 2-year terms by the active medical staff. The Medical Center Bylaws state that the CEB independently makes recommendations to the governing body regarding mechanisms used to review credentials and delineate clinical privileges, recommends individuals for medical staff membership, and assigns privileges for each practitioner. The bylaws also define the PSB as a body comprised of three physicians or other professionals, all appointed and chaired by the COS. The PSB reviews applications for appointments requiring an appraisal of professional qualifications and performance.

Based on interviews with two physicians who formerly served as COS, the President of the medical staff, three at-large members of the CEB, the Acting Chief of the Pathology and Laboratory Service, the Chief of the Neurology Service, the Chief of Psychiatry, and the Acting Chief of the Medical Service (who is the Assistant Chief of the Medical Service), OMI found that the procedure outlined below is the usual practice for processing initial applications for privileges and applications for reappraisals.

The service chief reviews the applications after the credentialing and privileging section collects the information required for a complete application. The application is then considered by the PSB, which is convened by the COS on an ad hoc basis. Other than the COS, there is no permanent membership of the PSB. Service chiefs with privileging applications under consideration are asked to attend the meeting, along with other available service chiefs to ensure the required three physicians are present. The relevant service chief reviews the pending application and leads the discussion of the applicant's credentials related to the requested privileges. The members of the PSB are given a short summary of the applicant's credentials, may refer to the applicant's credentialing file, and may question the service chief about the applicant's file or the facility's resources as related to the privileges requested by the applicant. No formal vote by PSB members recommending a referral of the application to the CEB is made; clarifications of requested privileges are returned to the applicant via the service chief and responses considered at a subsequent PSB meeting.

In the absence of questions by PSB members, the minutes of the meeting include a summary of the applicant's credentials, and the PSB's discussion. One former COS indicated that it was his practice to take the minutes into the Director the same day as the PSB meeting, to review the applications for initial privileges or reappraisal, and to obtain the Director's signature indicating approval. The other former COS indicated that the PSB minutes went to the Director for approval within 48 to 72 hours of the meeting; however, it was not her practice to personally brief him on the contents of those

minutes. OMI was unable to precisely determine when the COS or Director approved the PSB minutes, because in those minutes reviewed, none of the signatures were dated. Approval of the PSB minutes by the Director usually occurred prior to the next regularly scheduled meeting of the CEB, the body charged with making recommendations on privileging actions. On interview of the former COSs, OMI found that their submission of the PSB minutes to the Director for approval was based on the need to expeditiously approve the pending applications for privileges, not the intent to deceive the Director or by pass the CEB.

In January 2013, the Medical Center instituted an electronic vote by the CEB members to consider and approve PSB recommendations. Prior to that time, the minutes of the PSB meetings incorrectly indicated that a CEB vote had been taken. OMI was unable to verify that the electronic votes of the CEB membership had occurred. After January 2013, the secretary to the COS had the responsibility for electronic voting by preparing an e-mail addressed to the voting members of the CEB as soon as the PSB minutes became available. The e-mail, with minutes of the PSB attached, asked each member of the CEB to vote to approve the recommendations of the PSB. However, the results of this e-mail voting were not presented to the Director prior to his approval of the PSB minutes. E-mail approval of the PSB minutes did not get reported to the CEB until its next regularly scheduled meeting. CEB consideration of initial privileging applications and reappraisals consisted of acceptance of PSB minutes without the benefit of additional review or discussion of individual applicants.

The whistleblower stated that the Medical Center failed to follow its credentialing and privileging policies on an ongoing basis and provided two examples in which he alleged that the privileging of providers was not justified, according to agency-wide and local policy.

First Example

The first situation was that of an ophthalmologist employed by the Medical Center in June 2004. At a June 30, 2004, meeting (attended by the former COS, the Chief of Anesthesiology, the Chief of Surgical Service, the Acting Chief of Medical Service, and the Chief of Neurology), the PSB considered the ophthalmologist's credentials. The minutes of that meeting reflect an extensive review and discussion of the applicant's past education, training, medical licenses, past adverse actions, malpractice settlements, and restrictions. The minutes also reflect that his peer recommendations were positive. The PSB found his credentials were acceptable and recommended that initial privileges be approved. The Medical Center Director approved the minutes. This ophthalmologist underwent the reappraisal process, receiving full privileges on the usual 2-year cycle in June 2006, 2008, and 2010. However, the reappraisal in 2010 failed to include a review by the VISN 16 CMO as newly required by VHA Handbook 1100.19, para. 5.m.(5)(c)1, given that this applicant had one or more large malpractice claims at the time.

On April 26, 2012, the ophthalmologist placed an incorrect lens implant into a patient's left eye. At a May 1, 2012, meeting (attended by the former COS, Chief of Surgical Service, Chief of Medical Service, Chief of Anesthesiology, and another ophthalmologist), the PSB reviewed the ophthalmologist's surgical incident and proposed a temporary suspension of his privileges, pending a comprehensive review of his clinical practice and due process procedures. In a letter dated May 2, 2012, the Medical Center Director suspended the ophthalmologist's privileges. The Director chartered a root cause analysis (RCA) on May 1, 2012.¹ Members of the RCA team included the Chief of Ophthalmology, an operating room nurse, the Nurse Manager of the cardiac catheterization laboratory, and support staff. The team was charged with examining the events preceding the incident and making recommendations to assure that correct lenses be implanted in future cataract extraction and implantation procedures.

At a May 17, 2012, meeting (attended by the former COS, the Chief of Surgical Service, Chief of Neurology, and another staff physician), the PSB considered the ophthalmologist's privileges, which were to expire on May 20, 2012. Although he had submitted the necessary documents and otherwise met the requirements for repriviliging, the PSB recommended administratively denying his request, pending the results of the RCA. The PSB concluded that his reappraisal and repriviliging package would be reconsidered after the completion of the RCA, provided the RCA did not find that an Administrative Investigation needed to be convened, in accordance with the procedures specified in *VHA Handbook 1100.19* para. 6.k.(3)(e)1.b.

At a May 29, 2012, meeting (attended by the former COS, a physician representative from the Surgical Service, the Acting Chief of Pathology and Laboratory Medicine Service, the Chief of Anesthesiology Service, the Acting Chief of Radiology Service, the Chief of Medicine Service, the Chief of Neurology, and a psychologist representing the Mental Health Service), the PSB reviewed the ophthalmologist's credentials in detail, and recommended reinstatement of his privileges that had been on administrative hold due to his clinical suspension. However, the VISN 16 CMO had not yet reviewed the application for reinstatement of privileges as required, given that the applicant had one or more large malpractice claims. The Director signed the minutes but did not concur with the PSB's recommendation.

At a May 31, 2012, meeting the PSB recommended that the ophthalmologist's suspension of privileges be extended, pending further review of his surgical cases by two ophthalmologists who were not members of the Medical Center staff. Although not

¹ *Veterans Health Administration Handbook 1050.01* (March 4, 2011) para. 7 defines a RCA as a focused review that is used for all adverse events or close calls requiring analysis and are deemed confidential under 38 U.S.C. 5705. *VHA Handbook 1100.19* para. 6(1)(b) says confidential reviews like an RCA review may not be used during any portion of the review process for the granting of clinical privileges. However, if the results of an RCA suggest further investigation of an individual's action related to the adverse event, the Director can assign an administrative review which can be made available for appropriate action in the privileging process.

documented in the meeting minutes, OMI learned that this recommendation came about after discussion between the VISN 16 CMO and Medical Center leadership. From June 15 to September 8, 2012, each ophthalmologist reviewed 25 randomly selected cases.

On September 14, 2012, a Special Focus Professional Standards Board (SFPSB) comprised of the Acting COS at the time, Maurilio Garcia-Maldonado, M.D., the Chief of Surgical Service, and a physician representative from Surgical Service, met to consider the results of the ophthalmologists' review of the 50 cases. The SFPSB recommended that the provider's privileges be reconsidered by the PSB for reinstatement and continued monitoring. The Director did not sign the minutes of this meeting.

At an October 3, 2012, meeting (attended by the Acting COS, a physician representative from Surgical Service, the Chief of Surgical Service, the Chief of Anesthesiology Service, the Assistant Chief of Staff for Mental Health Service, and the Chief of Medical Service), the PSB conducted an extensive review of the ophthalmologist's record. However, without the required VISN 16 CMO input, the committee did not make a privileging recommendation, and the Director did not sign these minutes.

In an undated addendum to the October 3, 2012, minutes, the PSB recommended that:

- 1) The ophthalmologist undergo a focused professional practice evaluation in which each of his next 25 cataract extraction and lens implantation surgical procedures be proctored by the Chief of Ophthalmology Service.
- 2) The Chief of Ophthalmology Service provide a written report on his observations for each procedure.
- 3) The PSB will review these findings and make a final recommendation regarding granting full and unrestricted privileges upon completion of the 25 surgical procedures.

OMI learned that the PSB made the above recommendations following discussions with the VISN 16 CMO.

At a November 16, 2012, meeting (attended by the Acting COS, the Chief of Medical Service, the Chief of Surgical Service, and the Chief of Psychiatry Service), the PSB reconsidered the ophthalmologist's privileges. In a two-line addendum to the minutes of this meeting, the PSB recommended that the ophthalmologist's administrative hold be removed and his privileges restored with the recommended provisions. The addendum states that this recommendation was based on further review and discussion with the VISN 16 CMO. The Director signed and concurred with these minutes.

Also on November 16, 2012, the Director sent a memorandum to the ophthalmologist, granting him privileges with the following provisions:

- 1) The Chief of Ophthalmology Service will proctor by direct observation the next 25 cataract surgeries.
- 2) The Chief of Ophthalmology Service will provide a written report on the observations for each procedure, and the results for these 25 procedures will be reported to the PSB.
- 3) The PSB will review these findings and make a final recommendation regarding granting full and unrestricted privileges upon completion of the 25 surgical procedures.

On December 4, 2012, the ophthalmologist appealed the Director's offer. In a February 28, 2013, memorandum, the Director reaffirmed his decision to offer the ophthalmologist privileges with provisions, and on March 5, 2013, the ophthalmologist accepted this decision. As of June 5, 2013, he had completed 8 observed cataract surgeries of the 25 required.

OMI found no evidence that the CEB was involved in any of these actions regarding the ophthalmologist's privileges before the Director approved them.

Second Example

The second case of a provider who allegedly was not privileged according to local policy involved another ophthalmologist employed by the Medical Center in October 2011. At an October 14, 2011, meeting (attended by the Acting COS, the Chief of Surgical Service, the Chief of Medical Service, and the Chief of Psychiatry Service), the PSB considered the ophthalmologist's initial application for privileges. At the time, he was involved in three malpractice suits, two of which had been closed without payment, and one still in discovery. The ophthalmologist's credentials were discussed and the PSB decided to recommend granting the requested privileges. The Director approved the meeting minutes.

Following the completion of a training program to insert a new type of prosthetic lens, the ophthalmologist requested additional privileges on May 3, 2012. The PSB minutes reflect that his record was reviewed and that he had the necessary training to support this request. The malpractice suit that had been in discovery in his initial privileging was noted as closed without payment, and no additional malpractice suits were identified. The Medical Center Director approved the meeting minutes in which the ophthalmologist had requested these privileges.

OMI found no evidence that the CEB was involved in any of these actions regarding this second ophthalmologist's privileges before the Director approved them.

Conclusions

1. OMI substantiates the allegation that the Medical Center relied upon incorrect credentialing and privileging processes that were technically noncompliant with VHA policy and contrary to Medical Center Bylaws governing credentialing and privileging. VHA policy stipulates that the Executive Committee of the Medical Staff (in the Medical Center, the CEB) is the body charged with making credentialing and privileging recommendations to the facility Director. Although the Medical Center Director approved privileging and re-privileging requests before receiving the recommendation of the CEB, he approved them after a detailed consideration of the requests by and the recommendation of the PSB, another committee comprised of executive members of the Medical Center medical staff. Therefore, the Medical Center ensured oversight of the credentialing and privileging of medical staff members, but it was provided by the limited membership of the PSB, not by the full membership of the CEB, as required by the Medical Center Bylaws and policy. Although technically noncompliant with VHA policy, OMI believes the Medical Center did comply with the intent of the VHA policy requiring medical staff oversight of the credentialing and privileging of medical staff members (see conclusion 4 below).
2. OMI substantiates the allegation that the Medical Center was not providing sufficient information to the CEB for them to come to an informed recommendation about an applicant's credentials and requested privileges. In some instances, names were not provided; in other instances, names with only a short summary of the applicant's credentials were provided. In all instances, the voting members of the CEB did not have access to the minutes and the discussions of the PSB meetings on individual applicants. We conclude that the CEB was actually voting after the Director had already approved the privileges.
3. OMI substantiates the allegation that the electronic voting by the CEB on credentialing and privileging was incorrectly reported in PSB meeting minutes as having taken place. We found that privileging requests of physicians were reviewed by the PSB and submitted to the Medical Center Director for approval before the CEB voted. Although there was oversight mismanagement of the credentialing and privileging process and misstatements of facts, OMI found no evidence that there was intent to deceive by anyone on the PSB.
4. OMI does not substantiate the allegation that the Medical Center's improper credentialing and privileging practices may have resulted in incorrect privileging of providers. Although Medical Center leadership did not follow the privileging process outlined in its bylaws and VHA policy, there is overwhelming evidence in the two examples cited by the whistleblower that the Director, COS, and other clinical leaders were intimately involved with those privileging actions. In the first example, Medical Center leadership went to great lengths to assure the practice of the ophthalmologist was completely evaluated before, and closely monitored after, his return to clinical practice, even if this evaluation and monitoring took place within the

structure of the PSB rather than the CEB. In the second example, the PSB reviewed the malpractice claims against the ophthalmologist and made appropriate privileging recommendations to the Director.

5. The electronic voting system utilized by the Medical Center is not described or mentioned in either the VHA Handbook or the Medical Center's Bylaws or policies on the credentialing and privileging process.
6. OMI concludes that the Director's practice of not dating his signature on PSB meeting minutes made it difficult to validate the sequencing or timeliness of the Medical Center's credentialing and privileging process.

Recommendations

1. The Medical Center should revise its credentialing and privileging process to ensure that CEB members all have equal access to the individual applicant's credentials, and to the minutes of the PSB meetings, prior to the Director's approval. The future process must be compliant with VHA policy, Medical Center Bylaws, and local policy.
2. The Medical Center should review the utilization and effectiveness of their electronic voting system within the privileging process and if retained, develop a policy that clearly describes the purpose and operation of this system.
3. The Medical Center should ensure that all signatures by the Director on privileging documents are dated.

Attachment A
Documents Reviewed by OMI

1. Veterans Health Administration (VHA) Handbook 1100.19, *Credentialing and Privileging*, November 2008
2. G.V. (Sonny) Montgomery VA Medical Center, *Credentialing and Privileging of Independent Practitioners*, Medical Center Policy No. K-11-P-60, December 23, 2012
3. G.V. (Sonny) Montgomery VA Medical Center, *Professional Standards Board for Licensed Independent Practitioners (LIPs)*, Medical Center Policy No. BRD-11-09, December 10, 2012
4. G.V. (Sonny) Montgomery VA Medical Center, *Clinical Executive Board (CEB)*, May 21, 2013
5. G.V. (Sonny) Montgomery VA Medical Center, *Bylaws and Rules of The Medical Staff*, December 18, 2009
6. G.V. (Sonny) Montgomery VA Medical Center, Medical Staff Focused Professional Practice Evaluations and Ongoing Professional Practice Evaluations (FPPE/OPPE)
7. G.V. (Sonny) Montgomery VA Medical Center, *Clinical Executive Board Minutes*: April 9, 2013
8. G.V. (Sonny) Montgomery VA Medical Center, *Professional Standards Board Minutes*: June 30, 2004; June 28, 2008; May 21, 2010; October 14, 2011; May 1, 2012; May 3, 2012; May 17, 2012; May 29, 2012; May 31, 2012; June 3, 2012; June 21, 2012; September 14, 2012; October 3, 2012; November 16, 2012
9. Charter Memorandum and results for Root Cause Analysis, May 1, 2012
10. Medical Center Director's letter of privilege suspension for ophthalmologist, May 2, 2012
11. VISN 16 Chief Medical Officer (CMO) review of ophthalmologist's privilege request, October 3, 2012
12. Medical Center Director's Memorandum offering clinical privileges with provisions to ophthalmologist, November 16, 2012

13. Letter from ophthalmologist to Chief of Staff appealing accompanying provisions to his clinical privileges, December 6, 2012
14. Medical Center Director's Memorandum offering clinical privileges with provisions to ophthalmologist, February 28, 2013
15. Memorandums for the ophthalmologist's renewal of clinical privileges during the following time frames: June 2006 – June 2008, June 2008 – June 2010, and June 2010 – June 2012



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

August 13, 2013

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-13-2644

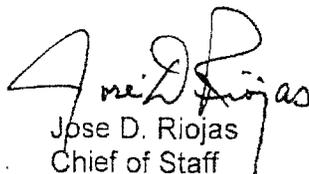
Dear Ms. Lerner:

I am responding to your letter regarding the Department of Veterans Affairs (VA) G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi (hereafter, the Medical Center), where an anonymous whistleblower alleged that by relying on credentialing and privileging (C&P) processes not in accordance with agency-wide and local policies, the leadership engaged in conduct that may constitute a violation of laws, rules, or regulations, an abuse of authority, and a substantial and specific danger to public health. The whistleblower also alleged that these C&P processes bypassed the Executive Committee charged with submitting recommendations to the Medical Center Director, that relevant information had been withheld from this Committee, that this Committee's votes had been falsely documented, and that the preceding activities led to the improper reprivileging of at least one physician. The Secretary has delegated to me the authority to sign this report and take any actions deemed necessary under 5 U.S.C. § 1213(d)(5).

The Secretary also asked the Under Secretary for Health to review this matter and to take any actions deemed necessary under 5 U.S.C. § 1213(d)(5). He, in turn, directed the Office of the Medical Inspector (OMI) to conduct an investigation. In its investigation, OMI substantiated three of the whistleblower's four allegations, confirming that the Medical Center's C&P practices were incorrect, that information had been withheld, and that false documentation had taken place, but did not substantiate the fourth – that these practices resulted in improper privileging of providers. OMI made three recommendations to the facility for improving its C&P processes. Findings from OMI's investigation are contained in the enclosed Final Report, which I am submitting for your review.

Thank you for the opportunity to respond to this issue.

Sincerely,


Jose D. Riojas
Chief of Staff

Enclosure

OFFICE OF THE MEDICAL INSPECTOR

**Report to the
Office of Special Counsel
OSC File Number DI-13-2644**

**Department of Veterans Affairs
G.V. (Sonny) Montgomery VA Medical Center
Jackson, Mississippi**



**Veterans Health Administration
Washington, DC**

**Report Date: July 12, 2013
2013-D-653**

Any information in this report that is the subject of the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty provisions of those statutes.

Executive Summary

Summary of Allegations

The Under Secretary for Health (USH) requested that the Office of the Medical Inspector (OMI) investigate complaints lodged with the Office of Special Counsel (OSC) by a Department of Veterans Affairs' (VA) employee (hereafter, the whistleblower) at the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi (hereafter, the Medical Center). The anonymous whistleblower alleged that by relying on credentialing and privileging processes that were not in accordance with agency-wide and local facility policies, the Medical Center may have violated laws, rules, or regulations, engaged in gross mismanagement and an abuse of authority, and created a substantial and specific danger to public health and safety. OMI conducted a site visit to the Medical Center on June 5-6, 2013.

The whistleblower's allegations are as follows:

1. The Medical Center employed incorrect credentialing and privileging processes that have led to the improper re-privileging of at least one physician in violation of agency policy.
2. Information including names, malpractice history, and disciplinary history about physicians who apply for credentialing or privileging is not being provided, as required by agency policy, to the Medical Center Clinical Executive Board (CEB) for its decision-making process.
3. CEB votes on credentialing and privileging were regularly and falsely reported as having been taken in meeting minutes of the Medical Center's Professional Standards Board (PSB).
4. These improper privileging and credentialing practices may have resulted in the incorrect privileging of additional practitioners.

Conclusions

1. OMI substantiates the allegation that the Medical Center relied upon incorrect credentialing and privileging processes that were technically noncompliant with Veterans Health Administration (VHA) policy and contrary to Medical Center Bylaws governing credentialing and privileging. VHA policy stipulates that the Executive Committee of the Medical Staff (in the Medical Center, the CEB) is the body charged with making credentialing and privileging recommendations to the facility Director. Although the Medical Center Director approved privileging and re-privileging requests before receiving the recommendation of the CEB, he approved them after a detailed consideration of the requests and recommendations by the PSB, another committee comprised of executive members of the Medical Center medical staff.

Therefore, the Medical Center ensured oversight of the credentialing and privileging of medical staff members, but it was provided by the limited membership of the PSB, not by the full membership of the CEB, as required by the Medical Center Bylaws and policy. Although technically noncompliant with VHA policy, OMI believes the Medical Center did comply with the intent of the VHA policy requiring medical staff oversight of the credentialing and privileging of medical staff members (see conclusion 4 below).

2. OMI substantiates the allegation that the Medical Center was not providing sufficient information to the CEB for them to come to an informed recommendation about an applicant's credentials and requested privileges. In some instances, names were not provided; in other instances, names with only a short summary of the applicant's credentials were provided. In all instances, the voting members of the CEB did not have access to the minutes and the discussions of the PSB meetings on individual applicants. It appears the CEB was actually voting after the Director had already approved the privileges.
3. OMI substantiates the allegation that the electronic voting by the CEB on credentialing and privileging was incorrectly reported in PSB meeting minutes as having taken place. We found that privileging requests of physicians were reviewed by the PSB and submitted to the Medical Center Director for approval before the CEB voted. Although there was oversight mismanagement of the credentialing and privileging process and misstatements of facts, OMI found no evidence that there was intent to deceive by anyone on the PSB.
4. OMI does not substantiate the allegation that the Medical Center's improper credentialing and privileging practices may have resulted in incorrect privileging of providers. Although Medical Center leadership did not follow the privileging process outlined in its bylaws and local policy, there is overwhelming evidence in the two examples cited by the whistleblower that the Director, Chief of Staff, and other clinical leaders were intimately involved with those privileging actions. In the first example, Medical Center leadership went to great lengths to ensure the practice of the ophthalmologist was completely evaluated before, and closely monitored after, his return to clinical practice, even if this evaluation and monitoring took place within the structure of the PSB rather than the CEB. In the second example, the PSB reviewed the malpractice claims against the ophthalmologist and made appropriate privileging recommendations to the Director.
5. The electronic voting system utilized by the Medical Center is not described or mentioned in either the VHA Handbook or the Medical Center Bylaws or policies on the credentialing and privileging process.
6. OMI concludes that the Director's practice of not dating his signature on PSB meeting minutes made it difficult to validate the sequencing or timeliness of the Medical Center's credentialing and privileging process.

Recommendations

1. The Medical Center should revise its credentialing and privileging process to ensure that CEB members all have equal access to the individual applicant's credentials, and to the minutes of the PSB meetings, prior to the Director's approval. The future process must be compliant with VHA policy, Medical Center Bylaws, and local policy.
2. The Medical Center should review the utilization and effectiveness of their electronic voting system within the privileging process and if retained, develop a policy that clearly describes the purpose and operation of this system.
3. The Medical Center should ensure that all signatures by the Director on privileging documents are dated.

Summary Statement

OMI's investigation did not find violations or apparent violations of statutory laws or mandatory rules or regulations as set forth in the Code of Federal Regulations. OMI did not find evidence of abuse of authority. OMI did not find evidence of a substantial and specific danger to the public health and safety at the Medical Center. However, OMI found the Medical Center technically noncompliant with VHA Handbook 1100.19, *Credentialing and Privileging*, and noncompliant with its own Medical Center Bylaws. OMI believes there was mismanagement in the administration of the credentialing and privileging processes.

I. Introduction

The Under Secretary for Health (USH) requested that the Office of the Medical Inspector (OMI) investigate complaints lodged with the Office of Special Counsel (OSC) by a Department of Veterans Affairs' (VA) employee (hereafter, the whistleblower) at the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi (hereafter, the Medical Center). The anonymous whistleblower alleged that by relying on credentialing and privileging processes that were not in accordance with agency-wide and local facility policies, the Medical Center may have violated laws, rules, or regulations, engaged in gross mismanagement and an abuse of authority, and created a substantial and specific danger to public health and safety. OMI conducted a site visit to the Medical Center on June 5-6, 2013.

II. Facility Profile

The Medical Center, part of Veterans Integrated Service Network (VISN) 16, consists of the main facility in Jackson, with 128 inpatient beds for general medicine, surgery, neurology, and mental health services, and seven community-based outpatient clinics. Special programs include treatment of cancer, spinal cord injury, Post-traumatic Stress Disorder, substance abuse, sleep studies, and dual diagnosis. The Medical Center is affiliated with the University of Mississippi and trains resident physicians in internal medicine and other specialty areas.

III. Allegations

The whistleblower's allegations are as follows:

1. The Medical Center employed incorrect credentialing and privileging processes that have led to the improper re-privileging of at least one physician in violation of agency policy.
2. Information including names, malpractice history, and disciplinary history about physicians who apply for credentialing or privileging is not being provided, as required by agency policy, to the Medical Center Clinical Executive Board (CEB) for its decision-making process.
3. CEB votes on credentialing and privileging were regularly and falsely reported as having been taken in meeting minutes of the Medical Center's Professional Standards Board (PSB).
4. These improper privileging and credentialing practices may have resulted in the incorrect privileging of additional practitioners.

IV. Conduct of Investigation

An OMI team consisting of (b) (6), the Deputy Medical Inspector for National Assessments; (b) (6) Clinical Psychologist, both from OMI, and (b) (6) Director, Credentialing and Privileging for the Veterans Health Administration (VHA), conducted the site visit. OMI reviewed relevant policies, procedures, reports, memorandums, and other documents (a complete list of which is in Attachment A) and held an entrance and an exit briefing with Medical Center leadership including (b) (6) Medical Center Director; (b) (6) Acting Chief of Staff (COS); (b) (6) Assistant Director; (b) (6) Acting Associate Director of Patient Care Services; and (b) (6) Chief of Medicine, who had recently served as interim COS.

OMI interviewed the following individuals:

- (b) (6) Medical Center Director;
- (b) (6) Executive Assistant, COS;
- (b) (6) Nephrologist (former COS);
- (b) (6) Chief of Medicine (former interim COS);
- (b) (6) Chief of Psychiatry;
- (b) (6) Acting Chief of Pathology and Laboratory Service;
- (b) (6) Chief of Neurology;
- (b) (6) Acting Chief of Surgery and Chief of Ophthalmology;
- (b) (6) President of the Medical Staff;
- (b) (6) elected Medical Staff Representative and at-large member of the CEB;
- (b) (6) elected Medical Staff Representative and at-large member of the CEB;
- (b) (6) elected Medical Staff Representative and at-large member of the CEB;
- (b) (6) staff ophthalmologist;
- (b) (6) Credentialing Coordinator;
- (b) (6) secretary to the COS; and
- (b) (6) Chief Medical Officer (CMO) VISN 16.

The Office of General Counsel reviewed OMI's findings to determine whether there was any violation of law, rule, or regulation.

OMI **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. OMI **did not substantiate** allegations when the facts showed the allegations were unfounded. OMI **could not substantiate** allegations when we found no conclusive evidence either to sustain or refute the allegations.

V. Findings

VHA Handbook 1100.19, *Credentialing and Privileging*, defines the policy for credentialing and privileging VA providers. Credentialing involves the verification of the individual's professional education; training; licensure; certification and health status; previous experience, including gaps in employment; clinical privileges; professional references; malpractice history and adverse actions; or criminal violations. The credentialing process ensures that each new applicant for appointment to the medical staff meets the requirements for the position and is entitled to the requested privileges.

Clinical privileging is the process by which the facility grants the applicant permission to independently provide specified patient care services within the scope of the applicant's license and clinical competence, and within the facility's capabilities. Clinical privileges are granted for no longer than 2 years, after which they must be reappraised and regranted. For providers who already hold clinical privileges within the facility, reappraisal of their credentials includes: the provider's statement about successful or pending challenges to licensure or registration; voluntary or involuntary relinquishment of licensure or registration; limitation, reduction, or loss of privileges at another hospital; loss of medical staff membership; pending malpractice claims or claims closed since the provider's last reappraisal; mental and physical status; and any other reasonable indicators of continuing qualification and competency.

VHA Handbook 1100.19 specifies that consideration of a provider's credentials and application for privileges, both at the initial appointment and on reappraisal, starts with the service chief's review, followed by a recommendation to the credentialing committee and the Medical Staff's Executive Committee. The Executive Committee recommends to the governing body (in VHA facilities, the Medical Center Director) to grant or deny the applicant or reapplicant's clinical privileges. Upon approval of the Executive Committee's recommendations, the Director informs the applicant or reapplicant, by letter, of the privileges granted.

Under the Medical Center Bylaws and rules of the medical staff, adopted December 18, 2009, the CEB functions as an authorized Executive Committee of the medical staff. The PSB functions as the credentialing committee.

The Medical Center defines its procedures for reviewing credentials and granting privileges in *Credentialing and Privileging of Independent Practitioners*, Medical Center Policy No. K-11-P-60 (December 31, 2012). The service chief reviews the applicant's or

reapplicant's credentials. In the case of reapplicants, this involves the practitioner's performance, judgment, clinical or technical competence, skills, an evaluation of physical and mental status, and current privileges. This policy states that the service chief's recommendation be reviewed by the PSB and then be submitted to the CEB.

The CEB is chaired by the COS and composed of 12 additional voting members: the President of the medical staff, the Service Chiefs of medicine, surgery, neurology, and mental health, the Chief of the Dental Service, the Chief of the Psychology Service, the Chief of the Pathology and Laboratory Medicine Service, and 4 at-large members elected to 2-year terms by the active medical staff. The Medical Center Bylaws state that the CEB independently makes recommendations to the governing body regarding mechanisms used to review credentials and delineate clinical privileges, recommends individuals for medical staff membership, and assigns privileges for each practitioner. The bylaws also define the PSB as a body comprised of three physicians or other professionals, all appointed and chaired by the COS. The PSB reviews applications for appointments requiring an appraisal of professional qualifications and performance.

Based on interviews with two physicians who formerly served as COS, the President of the medical staff, three at-large members of the CEB, the Acting Chief of the Pathology and Laboratory Service, the Chief of the Neurology Service, the Chief of Psychiatry, and the Acting Chief of the Medical Service (who is the Assistant Chief of the Medical Service), OMI found that the procedure outlined below is the usual practice for processing initial applications for privileges and applications for reappraisals.

The service chief reviews the applications after the credentialing and privileging section collects the information required for a complete application. The application is then considered by the PSB, which is convened by the COS on an ad hoc basis. Other than the COS, there is no permanent membership of the PSB. Service chiefs with privileging applications under consideration are asked to attend the meeting, along with other available service chiefs to ensure the required three physicians are present. The relevant service chief reviews the pending application and leads the discussion of the applicant's credentials related to the requested privileges. The members of the PSB are given a short summary of the applicant's credentials, may refer to the applicant's credentialing file, and may question the service chief about the applicant's file or the facility's resources as related to the privileges requested by the applicant. No formal vote by PSB members recommending a referral of the application to the CEB is made; clarifications of requested privileges are returned to the applicant via the service chief and responses considered at a subsequent PSB meeting.

In the absence of questions by PSB members, the minutes of the meeting include a summary of the applicant's credentials, and the PSB's discussion. One former COS indicated that it was his practice to take the minutes into the Director the same day as the PSB meeting, to review the applications for initial privileges or reappraisal, and to obtain the Director's signature indicating approval. The other former COS indicated that the PSB minutes went to the Director for approval within 48 to 72 hours of the meeting; however, it was not her practice to personally brief him on the contents of those

minutes. OMI was unable to precisely determine when the COS or Director approved the PSB minutes, because in those minutes reviewed, none of the signatures were dated. Approval of the PSB minutes by the Director usually occurred prior to the next regularly scheduled meeting of the CEB, the body charged with making recommendations on privileging actions. On interview of the former COSs, OMI found that their submission of the PSB minutes to the Director for approval was based on the need to expeditiously approve the pending applications for privileges, not the intent to deceive the Director or by pass the CEB.

In January 2013, the Medical Center instituted an electronic vote by the CEB members to consider and approve PSB recommendations. Prior to that time, the minutes of the PSB meetings incorrectly indicated that a CEB vote had been taken. OMI was unable to verify that the electronic votes of the CEB membership had occurred. After January 2013, the secretary to the COS had the responsibility for electronic voting by preparing an e-mail addressed to the voting members of the CEB as soon as the PSB minutes became available. The e-mail, with minutes of the PSB attached, asked each member of the CEB to vote to approve the recommendations of the PSB. However, the results of this e-mail voting were not presented to the Director prior to his approval of the PSB minutes. E-mail approval of the PSB minutes did not get reported to the CEB until its next regularly scheduled meeting. CEB consideration of initial privileging applications and reappraisals consisted of acceptance of PSB minutes without the benefit of additional review or discussion of individual applicants.

The whistleblower stated that the Medical Center failed to follow its credentialing and privileging policies on an ongoing basis and provided two examples in which he alleged that the privileging of providers was not justified, according to agency-wide and local policy.

First Example

The first situation was that of an ophthalmologist employed by the Medical Center in June 2004. At a June 30, 2004, meeting (attended by the former COS, the Chief of Anesthesiology, the Chief of Surgical Service, the Acting Chief of Medical Service, and the Chief of Neurology), the PSB considered the ophthalmologist's credentials. The minutes of that meeting reflect an extensive review and discussion of the applicant's past education, training, medical licenses, past adverse actions, malpractice settlements, and restrictions. The minutes also reflect that his peer recommendations were positive. The PSB found his credentials were acceptable and recommended that initial privileges be approved. The Medical Center Director approved the minutes. This ophthalmologist underwent the reappraisal process, receiving full privileges on the usual 2-year cycle in June 2006, 2008, and 2010. However, the reappraisal in 2010 failed to include a review by the VISN 16 CMO as newly required by VHA Handbook 1100.19, para. 5.m.(5)(c)1, given that this applicant had one or more large malpractice claims at the time.

On (b) (6) 2012, the ophthalmologist placed an incorrect lens implant into a patient's left eye. At a May 1, 2012, meeting (attended by the former COS, Chief of Surgical Service, Chief of Medical Service, Chief of Anesthesiology, and another ophthalmologist), the PSB reviewed the ophthalmologist's surgical incident and proposed a temporary suspension of his privileges, pending a comprehensive review of his clinical practice and due process procedures. In a letter dated May 2, 2012, the Medical Center Director suspended the ophthalmologist's privileges. The Director chartered a root cause analysis (RCA) on May 1, 2012.¹ Members of the RCA team included the Chief of Ophthalmology, an operating room nurse, the Nurse Manager of the cardiac catheterization laboratory, and support staff. The team was charged with examining the events preceding the incident and making recommendations to assure that correct lenses be implanted in future cataract extraction and implantation procedures.

At a May 17, 2012, meeting (attended by the former COS, the Chief of Surgical Service, Chief of Neurology, and another staff physician), the PSB considered the ophthalmologist's privileges, which were to expire on May 20, 2012. Although he had submitted the necessary documents and otherwise met the requirements for repriviling, the PSB recommended administratively denying his request, pending the results of the RCA. The PSB concluded that his reappraisal and repriviling package would be reconsidered after the completion of the RCA, provided the RCA did not find that an Administrative Investigation needed to be convened, in accordance with the procedures specified in *VHA Handbook 1100.19* para. 6.k.(3)(e)1.b.

At a May 29, 2012, meeting (attended by the former COS, a physician representative from the Surgical Service, the Acting Chief of Pathology and Laboratory Medicine Service, the Chief of Anesthesiology Service, the Acting Chief of Radiology Service, the Chief of Medicine Service, the Chief of Neurology, and a psychologist representing the Mental Health Service), the PSB reviewed the ophthalmologist's credentials in detail, and recommended reinstatement of his privileges that had been on administrative hold due to his clinical suspension. However, the VISN 16 CMO had not yet reviewed the application for reinstatement of privileges as required, given that the applicant had one or more large malpractice claims. The Director signed the minutes but did not concur with the PSB's recommendation.

At a May 31, 2012, meeting the PSB recommended that the ophthalmologist's suspension of privileges be extended, pending further review of his surgical cases by two ophthalmologists who were not members of the Medical Center staff. Although not

¹ *Veterans Health Administration Handbook 1050.01* (March 4, 2011) para. 7 defines a RCA as a focused review that is used for all adverse events or close calls requiring analysis and are deemed confidential under 38 U.S.C. 5705. *VHA Handbook 1100.19* para. 6(1)(b) says confidential reviews like an RCA review may not be used during any portion of the review process for the granting of clinical privileges. However, if the results of an RCA suggest further investigation of an individual's action related to the adverse event, the Director can assign an administrative review which can be made available for appropriate action in the privileging process.

documented in the meeting minutes, OMI learned that this recommendation came about after discussion between the VISN 16 CMO and Medical Center leadership. From June 15 to September 8, 2012, each ophthalmologist reviewed 25 randomly selected cases.

On September 14, 2012, a Special Focus Professional Standards Board (SFPSB) comprised of the Acting COS at the time, (b) (6) the Chief of Surgical Service, and a physician representative from Surgical Service, met to consider the results of the ophthalmologists' review of the 50 cases. The SFPSB recommended that the provider's privileges be reconsidered by the PSB for reinstatement and continued monitoring. The Director did not sign the minutes of this meeting.

At an October 3, 2012, meeting (attended by the Acting COS, a physician representative from Surgical Service, the Chief of Surgical Service, the Chief of Anesthesiology Service, the Assistant Chief of Staff for Mental Health Service, and the Chief of Medical Service), the PSB conducted an extensive review of the ophthalmologist's record. However, without the required VISN 16 CMO input, the committee did not make a privileging recommendation, and the Director did not sign these minutes.

In an undated addendum to the October 3, 2012, minutes, the PSB recommended that:

- 1) The ophthalmologist undergo a focused professional practice evaluation in which each of his next 25 cataract extraction and lens implantation surgical procedures be proctored by the Chief of Ophthalmology Service.
- 2) The Chief of Ophthalmology Service provide a written report on his observations for each procedure.
- 3) The PSB will review these findings and make a final recommendation regarding granting full and unrestricted privileges upon completion of the 25 surgical procedures.

OMI learned that the PSB made the above recommendations following discussions with the VISN 16 CMO.

At a November 16, 2012, meeting (attended by the Acting COS, the Chief of Medical Service, the Chief of Surgical Service, and the Chief of Psychiatry Service), the PSB reconsidered the ophthalmologist's privileges. In a two-line addendum to the minutes of this meeting, the PSB recommended that the ophthalmologist's administrative hold be removed and his privileges restored with the recommended provisions. The addendum states that this recommendation was based on further review and discussion with the VISN 16 CMO. The Director signed and concurred with these minutes.

Also on November 16, 2012, the Director sent a memorandum to the ophthalmologist, granting him privileges with the following provisions:

- 1) The Chief of Ophthalmology Service will proctor by direct observation the next 25 cataract surgeries.
- 2) The Chief of Ophthalmology Service will provide a written report on the observations for each procedure, and the results for these 25 procedures will be reported to the PSB.
- 3) The PSB will review these findings and make a final recommendation regarding granting full and unrestricted privileges upon completion of the 25 surgical procedures.

On December 4, 2012, the ophthalmologist appealed the Director's offer. In a February 28, 2013, memorandum, the Director reaffirmed his decision to offer the ophthalmologist privileges with provisions, and on March 5, 2013, the ophthalmologist accepted this decision. As of June 5, 2013, he had completed 8 observed cataract surgeries of the 25 required.

OMI found no evidence that the CEB was involved in any of these actions regarding the ophthalmologist's privileges before the Director approved them.

Second Example

The second case of a provider who allegedly was not privileged according to local policy involved another ophthalmologist employed by the Medical Center in October 2011. At an October 14, 2011, meeting (attended by the Acting COS, the Chief of Surgical Service, the Chief of Medical Service, and the Chief of Psychiatry Service), the PSB considered the ophthalmologist's initial application for privileges. At the time, he was involved in three malpractice suits, two of which had been closed without payment, and one still in discovery. The ophthalmologist's credentials were discussed and the PSB decided to recommend granting the requested privileges. The Director approved the meeting minutes.

Following the completion of a training program to insert a new type of prosthetic lens, the ophthalmologist requested additional privileges on May 3, 2012. The PSB minutes reflect that his record was reviewed and that he had the necessary training to support this request. The malpractice suit that had been in discovery in his initial privileging was noted as closed without payment, and no additional malpractice suits were identified. The Medical Center Director approved the meeting minutes in which the ophthalmologist had requested these privileges.

OMI found no evidence that the CEB was involved in any of these actions regarding this second ophthalmologist's privileges before the Director approved them.

Conclusions

1. OMI substantiates the allegation that the Medical Center relied upon incorrect credentialing and privileging processes that were technically noncompliant with VHA policy and contrary to Medical Center Bylaws governing credentialing and privileging. VHA policy stipulates that the Executive Committee of the Medical Staff (in the Medical Center, the CEB) is the body charged with making credentialing and privileging recommendations to the facility Director. Although the Medical Center Director approved privileging and re-privileging requests before receiving the recommendation of the CEB, he approved them after a detailed consideration of the requests by and the recommendation of the PSB, another committee comprised of executive members of the Medical Center medical staff. Therefore, the Medical Center ensured oversight of the credentialing and privileging of medical staff members, but it was provided by the limited membership of the PSB, not by the full membership of the CEB, as required by the Medical Center Bylaws and policy. Although technically noncompliant with VHA policy, OMI believes the Medical Center did comply with the intent of the VHA policy requiring medical staff oversight of the credentialing and privileging of medical staff members (see conclusion 4 below).
2. OMI substantiates the allegation that the Medical Center was not providing sufficient information to the CEB for them to come to an informed recommendation about an applicant's credentials and requested privileges. In some instances, names were not provided; in other instances, names with only a short summary of the applicant's credentials were provided. In all instances, the voting members of the CEB did not have access to the minutes and the discussions of the PSB meetings on individual applicants. We conclude that the CEB was actually voting after the Director had already approved the privileges.
3. OMI substantiates the allegation that the electronic voting by the CEB on credentialing and privileging was incorrectly reported in PSB meeting minutes as having taken place. We found that privileging requests of physicians were reviewed by the PSB and submitted to the Medical Center Director for approval before the CEB voted. Although there was oversight mismanagement of the credentialing and privileging process and misstatements of facts, OMI found no evidence that there was intent to deceive by anyone on the PSB.
4. OMI does not substantiate the allegation that the Medical Center's improper credentialing and privileging practices may have resulted in incorrect privileging of providers. Although Medical Center leadership did not follow the privileging process outlined in its bylaws and VHA policy, there is overwhelming evidence in the two examples cited by the whistleblower that the Director, COS, and other clinical leaders were intimately involved with those privileging actions. In the first example, Medical Center leadership went to great lengths to assure the practice of the ophthalmologist was completely evaluated before, and closely monitored after, his return to clinical practice, even if this evaluation and monitoring took place within the

structure of the PSB rather than the CEB. In the second example, the PSB reviewed the malpractice claims against the ophthalmologist and made appropriate privileging recommendations to the Director.

5. The electronic voting system utilized by the Medical Center is not described or mentioned in either the VHA Handbook or the Medical Center's Bylaws or policies on the credentialing and privileging process.
6. OMI concludes that the Director's practice of not dating his signature on PSB meeting minutes made it difficult to validate the sequencing or timeliness of the Medical Center's credentialing and privileging process.

Recommendations

1. The Medical Center should revise its credentialing and privileging process to ensure that CEB members all have equal access to the individual applicant's credentials, and to the minutes of the PSB meetings, prior to the Director's approval. The future process must be compliant with VHA policy, Medical Center Bylaws, and local policy.
2. The Medical Center should review the utilization and effectiveness of their electronic voting system within the privileging process and if retained, develop a policy that clearly describes the purpose and operation of this system.
3. The Medical Center should ensure that all signatures by the Director on privileging documents are dated.

Attachment A
Documents Reviewed by OMI

1. Veterans Health Administration (VHA) Handbook 1100.19, *Credentialing and Privileging*, November 2008
2. G.V. (Sonny) Montgomery VA Medical Center, *Credentialing and Privileging of Independent Practitioners*, Medical Center Policy No. K-11-P-60, December 23, 2012
3. G.V. (Sonny) Montgomery VA Medical Center, *Professional Standards Board for Licensed Independent Practitioners (LIPs)*, Medical Center Policy No. BRD-11-09, December 10, 2012
4. G.V. (Sonny) Montgomery VA Medical Center, *Clinical Executive Board (CEB)*, May 21, 2013
5. G.V. (Sonny) Montgomery VA Medical Center, *Bylaws and Rules of The Medical Staff*, December 18, 2009
6. G.V. (Sonny) Montgomery VA Medical Center, Medical Staff Focused Professional Practice Evaluations and Ongoing Professional Practice Evaluations (FPPE/OPPE)
7. G.V. (Sonny) Montgomery VA Medical Center, *Clinical Executive Board Minutes*: April 9, 2013
8. G.V. (Sonny) Montgomery VA Medical Center, *Professional Standards Board Minutes*: June 30, 2004; June 28, 2008; May 21, 2010; October 14, 2011; May 1, 2012; May 3, 2012; May 17, 2012; May 29, 2012; May 31, 2012; June 3, 2012; June 21, 2012; September 14, 2012; October 3, 2012; November 16, 2012
9. Charter Memorandum and results for Root Cause Analysis, May 1, 2012
10. Medical Center Director's letter of privilege suspension for ophthalmologist, May 2, 2012
11. VISN 16 Chief Medical Officer (CMO) review of ophthalmologist's privilege request, October 3, 2012
12. Medical Center Director's Memorandum offering clinical privileges with provisions to ophthalmologist, November 16, 2012

13. Letter from ophthalmologist to Chief of Staff appealing accompanying provisions to his clinical privileges, December 6, 2012
14. Medical Center Director's Memorandum offering clinical privileges with provisions to ophthalmologist, February 28, 2013
15. Memorandums for the ophthalmologist's renewal of clinical privileges during the following time frames: June 2006 – June 2008, June 2008 – June 2010, and June 2010 – June 2012