Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 17-00602-342

Healthcare Inspection

Quality of Care Concerns in Thoracic Surgery Bay Pines VA Healthcare System Bay Pines, Florida

August 16, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to allegations from anonymous complainant(s) regarding the quality of care provided by a thoracic surgeon at the Bay Pines VA Healthcare System (system), Bay Pines, FL.

The complainant(s) alleged that:

- A thoracic surgeon at the system is incompetent.
- This incompetence has resulted in a high rate of complications and patient deaths.
- The thoracic surgeon has forbidden the surgical critical care team to care for his patients.
- A part-time surgeon resigned because he could no longer bear the thoracic surgeon's incompetence.
- The Chief of Surgery fired a surgeon for raising concerns regarding the thoracic surgeon's skills.
- The Chief of Staff and System Director knew about the thoracic surgeon's incompetence and did nothing to address it.

We did not substantiate that the thoracic surgeon was incompetent. The surgeon's credentialing and privileging files documented that he had the requisite education, training, experience, and skill set to perform up to a defined expectation.[1] In late 2016, a thoracic surgeon from another system directly observed the thoracic surgeon's operative skills and did not have concerns regarding his surgical technique. However, we identified a deficiency in the system's process for evaluating the competency of surgeons. Contrary to VA policy, the criteria used in the focused professional practice evaluation (FPPE) were not privilege-specific and therefore inadequate to fully assess the provider's skills.

The Acting Deputy Under Secretary for Health for Operations and Management (DUSHOM) sent a memorandum to Veterans Integrated Service Network (VISN) Directors on August 29, 2016 which specified that as of August 2017, another provider with similar training and privileges should conduct FPPEs and ongoing professional practice evaluations (OPPE).[2] We reviewed the thoracic surgeon's OPPE for the period from February 1, 2015 through January 31, 2017 and determined that an administrative psychiatrist conducted the surgeon's OPPE. The thoracic surgeon's OPPE had been completed prior to the issuance of the August 29, 2016 DUSHOM memorandum; we did not identify another OPPE that had since been completed by a provider of similar competence and training to that of the thoracic surgeon.

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
[2] DUSHOM VA Memorandum, *Requirements for Peer Review of Solo Practitioners,* August 29, 2016.

We did not substantiate that the surgeon had a high rate of complications. The surgeon's rate of conversion from thoracoscopic to open procedures fell within the range associated with this procedure in the medical literature.

We reviewed VHA mortality data but cannot discuss the data, which are confidential and privileged under the provisions of 38 U.S.C. 5705.[3] We did not identify specific quality of care concerns in the surgeon's mortality cases we reviewed.

The anonymous complainant(s) provided nine specific patient cases as examples of the allegations. We consulted with a thoracic surgeon, who did not identify quality of care concerns regarding the surgical treatment of the nine patients. We also identified six deaths occurring within 30 days of a thoracic surgical procedure that were not included in the list of patients provided by the complainant(s). We did not identify quality of care concerns with these cases.

We substantiated that the thoracic surgeon requested that the critical care team not care for his patients. The thoracic surgeon disagreed with the critical care team's approach to post-operative fluid management and preferred to direct his patients' fluid management. We determined that he had the authority to do so under the system's policy.

We could not substantiate that surgeons left the system because of quality of care concerns related to the thoracic surgeon, or that the Chief of Staff and/or System Director were aware of concerns regarding the thoracic surgeon's competence yet failed to address them.

We recommended that:

- The System Director ensure that focused professional practice evaluations review criteria are sufficient to evaluate the privilege-specific competence for thoracic surgeons.

- The System Director ensure that ongoing professional practice evaluation reviews are conducted by providers with training and privileges similar to those of the provider under review.

[3] VHA Handbook 1102.01. *National Surgery Office*, January 30, 2013. VHA maintains and collects morbidity and mortality data for surgical procedures performed by hospitals through the Veterans Affairs Surgical Quality Improvement Program (VASQIP). As an established medical quality assurance database, VASQIP data meet the requirements for confidentiality as mandated in 38 U.S.C. 5705 and its implementing regulations.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes B and C, pages 13–15 for the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to allegations from anonymous complainant(s) regarding the quality of care provided by a thoracic surgeon; specifically, that a thoracic surgeon's incompetence led to a high rate of complications and death and leadership did nothing to address the problem at the Bay Pines VA Healthcare System (system), Bay Pines, FL.

Background

The System

The system has a 1a complexity level[4] designation, and provides primary and tertiary care for more than 100,000 veterans. Services offered at the system include medical, surgical, psychiatric, and extended care in outpatient, inpatient, residential, nursing home, and home care settings. The system has 144 acute care inpatient beds, including 22 ICU beds. The Surgery Service is designated as a "complex" operative complexity level[5] and is comprised of General Surgery, Otolaryngology, Gynecology, Ophthalmology, Optometry, Spinal Neurosurgery, Orthopedics, Plastic/Hand/Wound Surgery, Podiatry, Thoracic Surgery, Vascular Surgery, and Urology.

Credentialing and Privileging Process

Credentialing is a "systematic process of screening and evaluating a practitioner's qualifications including, but not limited to, licensure, required education, relevant training and experience, and current competence and health status."[6] Privileging refers to the process of approving the procedures and services a practitioner can provide. A practitioner's clinical privileges are based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training, and licensure. Clinical privileges must be system-specific, service-specific, and practitioner-specific.[7]

[4] Veterans Health Administration facilities are categorized according to complexity level which is determined on the basis of patient population, clinical services offered, educational and research missions and administrative complexity. Facilities are classified into three levels with Level 1 representing the most complex facilities, Level 2 moderately complex facilities, and Level 3 the least complex facilities. Level 1 is further subdivided into descending levels of complexity represented by categories 1a - 1c. *2010 VHA System Quality and Safety Report.* Accessed November 28, 2016.

[5] VA assigned each of its inpatient medical centers an "operative complexity" level of standard, intermediate, or complex. The designations are based on facilities, equipment, workload, and staffing load. These measures were implemented per VHA Directive 2010-018, *System Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 7, 2010. This VHA Directive expired May 31, 2015 and has not yet been updated. http://vaww.dushom.va.gov/DUSHOM/surgery/Operative_Complexity.asp Accessed November 28, 2016.

[6] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[7] Ibid.

VHA Handbook 1100.19[8] specifies that providers must be re-privileged every two years. As part of the re-privileging process, service chiefs conduct ongoing assessments of provider competence. The handbook further specifies that:

> *Evaluation of professional performance, judgment, and clinical and/or technical competence and skills is to be based in part on results of practitioner-specific performance improvement activities and data analysis. Ongoing reviews conducted by service chiefs must be comprised of activities with defined criteria that emphasize the facility's performance improvement plan, appropriateness of care, patient safety, and desired outcomes...*[9]

Common Thoracic Surgical Procedures

Thoracic surgery is defined as surgery on the organs located between the neck and the diaphragm. This includes surgery on the heart and lungs, esophagus, trachea, pleura (lining between the lungs and the chest wall), mediastinum,[10] and chest wall.[11] Several common types of thoracic surgical procedures are described as follows.

A thoracotomy is a surgical opening of the chest. It is performed to evaluate and treat pulmonary problems when noninvasive procedures are non-diagnostic or unlikely to offer definitive treatment.[12]

Video Assisted Thoracic Surgery (VATS) is an alternative to an open thoracotomy. In VATS, a surgeon makes a small incision in the chest wall and introduces a scope with a miniature camera into the patient's thorax. Assisted by the camera, the surgeon views the anatomy and manipulates instruments necessary to perform the operation. VATS provides adequate visualization despite limited access to the thorax. This minimally invasive procedure allows a shorter operating time, less post-operative morbidity, and an earlier return to normal activity than with thoracotomy.

A pneumonectomy is a surgical procedure in which an entire lung is removed. A pneumonectomy is most often performed for lung cancer patients when the tumor cannot be resected by removal of a smaller portion of the lung. A pneumonectomy is an open procedure that requires a thoracotomy.

Allegations

On October 25, 2016, we received anonymous allegations concerning the Thoracic Surgery Service at the system. The anonymous complainant(s) alleged:

- A thoracic surgeon at the system is incompetent.

[8] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
[9] Ibid.
[10] The mediastinum is the space in the chest between the pleural sacs of the lungs that contains all the viscera of the chest except the lungs and pleurae https://www.merriam-webster.com/dictionary/mediastinum Accessed April 24, 2017.
[11] http://www.dictionary.com/browse/chest-wall Accessed February 15, 2April 24, 2017.
[12] http://www.merckmanuals.com/professional/SearchResults?query=thoracotomy. Accessed April 24, 2017.

- This incompetence has resulted in a high rate of complications and patient deaths.
- The thoracic surgeon has forbidden the surgical critical care team to care for his patients.
- A part-time surgeon resigned because he could no longer bear the thoracic surgeon's incompetence.
- The Chief of Surgery fired a surgeon for raising concerns regarding the thoracic surgeon's skills.
- The Chief of Staff and System Director knew about the thoracic surgeon's incompetence and did nothing to address it.

Scope and Methodology

We initiated our inspection on November 9, 2016 and completed our work February 17, 2017. We conducted site visits November 10, 21, and December 2, 2016. We interviewed system clinical care providers and staff knowledgeable about Surgery Services clinical operations. We reviewed patient electronic health records (EHR) from fiscal years (FY) 2014 to 2017, system and national policies, patient safety documents, medical journal articles, credentialing and privileging files, peer review records, and other documents relevant to these allegations. We consulted with a thoracic surgeon.

VHA Directive 2010-018, *System Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures* cited in this report expired May 31, 2015. We considered this policy to be in effect, as it has not been superseded by a more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),[13] the VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[14] The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of documents over which their program offices have primary responsibility."[15]

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

[13] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.
[14] VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document*, June 29, 2016.
[15] Ibid.

We 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

Issue 1: Surgical Competence

We did not substantiate that the surgeon was incompetent, based on our review of the surgeon's credentialing and privileging files, a thoracic surgical consultant's analysis of cases identified by the complainant(s), another surgeon's proctoring of the provider in question, and our own review of perioperative care in cases we identified during the course of our inspection.

However, we identified a deficiency in the system's process for evaluating the competency of surgeons. Contrary to VA policy,[16] the criteria used for professional competency determinations in focused professional practice evaluations (FPPE) and ongoing professional practice evaluations (OPPE) for the thoracic surgeon were not privilege-specific and therefore inadequate to fully assess his surgical skills.

Credentialing and Privileging

VHA Handbook 1100.19[17] defines the competence of physicians as "a documented demonstration of an individual having the requisite or adequate abilities or qualities capable to perform up to a defined expectation."

In December 2016, the thoracic surgeon was a full-time VA employee, hired in June 2013. The surgeon's credentialing and privileging file contained evidence that the provider had an active, valid license to practice medicine in a state within the United States, which fulfills VA's requirements for licensure. We independently verified with the state medical board that this surgeon had an active, unrestricted license to practice medicine. In addition, we verified that the licensing state medical board had no record of disciplinary action against this provider.

We also verified that the surgeon had valid privileges at the system to perform all of the thoracic surgical procedures discussed in this report. In addition, the surgeon had similar privileges at another VHA facility to perform thoracotomies and "other operations of the lungs."

Professional Competency Determinations

To obtain and maintain privileges in the VA, VHA policy requires that physicians undergo an initial FPPE when new to the system, or requesting new privileges. Clinical and surgical service chiefs within a system must also conduct OPPEs[18] on a regular basis to ensure that providers are maintaining their clinical skills.

VHA policy defines FPPE as:

[16] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
[17] Ibid.
[18] Ibid.

> *…an oversight process to be employed by the facility when a practitioner does not have the documented evidence of competent performance of the privileges requested. It is a process whereby the facility evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges of the facility.*[19]

The FPPE is time limited, and requires medical staff leadership to review the competence of a new provider, or a provider who is requesting additional privileges from the system.[20]

The system conducted an FPPE of the thoracic surgeon to verify competency between June and December 2013. The Chief of Surgery at the time certified that no quality of care issues were identified during this review. However, the FPPE's competency criteria was limited to: (1) whether the surgeon obtained medical histories and conducted physical examinations within 24 hours of a patient's hospital admission; (2) timely responded to surgical consult requests; and (3) timely completed medical record documentation. We also found that the FPPE did not address provider-specific items, such as surgical complication rates, that would allow the system to assess a provider's skills in accordance with VA policy.[21] Additionally, the criteria did not relate to clinical diagnoses, treatments or surgical outcomes, but focused on documentation requirements and were therefore insufficient to evaluate "the privilege-specific competence of the practitioner."[22]

The Acting Deputy Under Secretary for Health for Operations and Management (DUSHOM) sent a memorandum to Veterans Integrated Service Network (VISN) Directors on August 29, 2016 which specified that as of August 2017, another provider with similar training and privileges should conduct FPPEs and OPPEs.[23]

We reviewed the thoracic surgeon's OPPE for the period from February 1, 2015 through January 31, 2017. We determined that the form used to complete surgical OPPEs at the system included reviews of deaths within 30 days of surgery, completion of a history and physical within 30 days of surgery and timeliness of operative notes as evidence of general competencies in patient care. An administrative psychiatrist conducted the surgeon's OPPE. The thoracic surgeon's OPPE had been completed prior to the issuance of the August 29, 2016 DUSHOM memorandum; we did not identify another OPPE that had since been completed by a provider of similar competence and training to that of the thoracic surgeon.

Based on our onsite recommendation, the system arranged for the surgeon to be proctored on December 19 and 20, 2016. A thoracic surgeon from another system directly observed the thoracic surgeon's operative skills, and did not have concerns regarding his surgical technique. The conclusions of the proctor and additional

[19] VHA Handbook 1100.19, *Credentialing and Privileging,* October 15, 2012.
[20] Ibid.
[21] Ibid.
[22] Ibid.
[23] VA Memorandum, "*Requirements for Peer Review of Solo Practitioners,*" August 29, 2016.

documentation of the provider's education and training in the credentialing and privileging files supported that the surgeon had "the requisite or adequate abilities or qualities capable to perform up to a defined expectation."[24]

Issue 2: Complication Rates and Surgical Deaths

We did not substantiate that the thoracic surgeon had high complication rates. We clarified in interviews that concerns regarding complication rates stemmed from the perception that the thoracic surgeon had a high rate of conversion from VATS to open thoracotomies. We found that the surgeon's rate of conversion from thoracoscopic to open procedures fell within published rates.

Complication Rates

Conversions from a VATS to an open thoracotomy can occur as a result of perioperative complications, technical reasons, anatomy, or characteristics of a tumor.[25] Published rates in the literature for conversion of thoracoscopies to open thoracotomies are highly variable. Quoted rates range between 2 to 23 percent, with higher conversion rates being associated with more advanced non-small cell lung cancer.[26][27] Rates of conversion typically decreased as the experience of the surgeon increased.[28]

We reviewed the thoracic surgeon's rate of conversion from VATS to open thoracotomies from FY 2014 through February 6, 2017. During this period, the thoracic surgeon performed 269 VATS. Of those, 31 (12 percent) were converted to open thoracotomies. By comparison, another thoracic surgeon at the system performed 80 VATS during the same period, with 12 conversions (15 percent) to open thoracotomies.

A thoracic surgeon consultant reviewed nine cases of patients identified by the complainant(s) as having poor surgical outcomes. The consultant confirmed that the incidence of complications in the reviewed cases did not result from poor quality care, and that the system's overall conversion rate from lobectomies to pneumonectomies did not suggest poor quality of care or an increased number of complications.

[24] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
[25] Dziedzic, Dariusz and Tadeusz Orlowski. *"The Role of VATS in Lung Cancer Surgery: Current Status and Prospects for Development."* July 21, 2015. Accessed February 16, 2017.
[26] Hanna et al., *"Contraindications of Video-assisted Thoracoscopic Surgical Lobectomy and Determinants of Conversion to Open*, Journal of Thoracic Disease, August 5, 2013. Accessed February 16, 2017.
[27] Samson et al., *"Predictors of Conversion to Thoracotomy for Video-assisted Thoracoscopic Lobectomy: A Retrospective Analysis and the Influence of Computed Tomography-based Calcification Assessment."* The Journal of Thoracic and Cardiovascular Surgery June 2013. Accessed February 16, 2017.
[28] Puri et al., *"Intraoperative Conversion from Video-assisted Thoracoscopic Surgery Lobectomy to Open Thoracotomy: A Study of Causes and Implications."* The Journal of Thoracic and Cardiovascular Surgery, 149:1 January 2015. Accessed February 16, 2017.

Surgical Deaths

We reviewed VHA mortality data but cannot discuss the data which are confidential and privileged under the provisions of 38 U.S.C. 5705.[29] We did not identify specific quality of care concerns in the surgeon's mortality cases we reviewed.

We reviewed nine cases identified by the complainant(s) as examples of poor quality of care provided by the thoracic surgeon, in conjunction with the thoracic surgical consultant. Of those patients, five died within 30 days of a thoracic surgical procedure. For all nine patients we determined that the patients were informed of the risks and benefits of the procedures prior to surgery; the procedures were clinically indicated; all nine patients underwent pre-operative clearance with cardiology consultation as appropriate; and the surgeon's surgical approach, identification of anatomical landmarks, and overall operative techniques were satisfactory.

We also identified six deaths occurring within 30 days of a thoracic surgical procedure performed by the thoracic surgeon in question that were not included in the list of patients provided by the complainant(s). We independently reviewed these cases and did not identify operative quality of care issues.

Issue 3: Surgical Critical Care Team Care

We substantiated that the thoracic surgeon did not permit the surgical critical care team to care for his patients, but determined that the thoracic surgeon had the authority to make this decision under the system's intensive care unit policy.

The system's Surgical Intensive Care Unit Policy[30] stated that the surgical intensive care unit (SICU) was a part of the surgery service, and that the thoracic surgeon or his designee would "be responsible for the care of patients admitted to SICU."[31] In interviews, the thoracic surgeon stated that he disagreed with the critical care team's approach to post-operative fluid management, and informed the surgeon leading the critical care team that he no longer wanted him to care for his patients. As the surgeon responsible for caring for patients admitted to the SICU, the thoracic surgeon's decision not to permit the critical care team to care for his patients did not violate system policy.

Issue 4: Surgeon Resignation

We did not substantiate that a surgeon resigned because of concerns regarding the quality of care provided by the thoracic surgeon. We interviewed the surgeon who

[29] VHA Handbook 1102.01. *National Surgery Office*, January 30, 2013. VHA maintains and collects morbidity and mortality data for surgical procedures performed by hospitals through the Veterans Affairs Surgical Quality Improvement Program (VASQIP). As an established medical quality assurance database, VASQIP data meet the requirements for confidentiality as mandated in 38 U.S.C. 5705 and its implementing regulations.
[30] System Surgery Service Policy 112-005, issued October 2014.
[31] System Surgery Service Policy 112-005.

resigned. He told us that he left the system for a planned retirement, not because of concerns regarding the quality of care the thoracic surgeon provided to patients.

This was confirmed by our review of the surgeon's exit documentation. The surgeon retired on January 3, 2016. In an email to the Chief of Surgery on October 13, 2015, the surgeon stated that he was "expecting to retire sometime within the next 3-6 months." He further stated that his "tour at Bay Pines has been a pure joy…"

We determined that the surgeon voluntarily retired from the system, and did not resign because of concerns regarding the quality of care provided by the thoracic surgeon.

Issue 5: Surgeon Termination

We could not substantiate that a surgeon was terminated for raising concerns regarding the thoracic surgeon's operative skills.

The surgeon was a fee basis provider, meaning that he received payment for specific services rendered on an as-needed basis. The Secretary of the VA has the authority under 38 U.S.C. 7405 to employ "without regard to civil service or classification laws, rules, or regulations" certain personnel on a fee-for-service basis, including physicians. The surgeon in question held a fee basis appointment from October 5, 2014 through October 10, 2016. He was privileged to practice as a surgeon at the system from October 1, 2014 through September 30, 2016. The system elected not to renew his privileges.

The provider who left the system told us in an interview that he believed he had been terminated because he raised concerns about the thoracic surgeon's competency. However, he could not provide documentation that he had raised these concerns to leadership. The provider's exit review listed the reason for leaving the system as "other."

The Chief of Surgery and Chief of Staff stated in interviews that the provider's services were no longer needed at the system, and that patient care needs could be met through the use of full-time surgical staff. VA policy regarding the use of fee basis employees states that they will be utilized when health services "are not otherwise readily available, when it is cost effective, or when the utilization is focused on the service or task to be performed rather than on a specific tour of duty."[32]

Issue 6: Senior Management Involvement

We could not substantiate that the Chief of Staff and System Director knew about the thoracic surgeon's alleged incompetence and did nothing to address it. The Chief of Staff and System Director denied that any concerns had been brought to them either in writing or other means. While several staff members voiced concerns during our interviews regarding the thoracic surgeon's competency and believed that the Chief of

[32] VA Handbook 5011/27, *Hours of Duty and Leave,* October 21, 2014.

Staff was aware of staff concerns, these individuals could not provide us with documentation of having raised these issues to the Chief of Staff or System Director. They also stated that they personally had not brought these concerns forward to system leadership.

Conclusions

We did not substantiate that the thoracic surgeon in question was incompetent, based upon our review of the provider's credentialing and privileging files, a thoracic surgery consultant's assessment of the cases identified by the complainant, another thoracic surgeon proctoring the provider, and our review of perioperative care in cases identified during the inspection. The system had documented evidence that the surgeon had the requisite skills and abilities to perform thoracic surgery at the system.

However, we identified a deficiency in the system's process for evaluating the competency of surgeons. Contrary to VA policy, the criteria used in the focused professional practice evaluation were not privilege-specific and therefore inadequate to fully assess the provider's skills.

The DUSHOM sent a memorandum to VISN Directors on August 29, 2016, which specified that as of August 2017 another provider with similar training and privileges should conduct FPPEs and OPPEs.[33] We reviewed the thoracic surgeon's OPPE for the period from February 1, 2015 through January 31, 2017 and determined that an administrative psychiatrist conducted the surgeon's OPPE. The thoracic surgeon's OPPE had been completed prior to the issuance of the August 29, 2016 DUSHOM memorandum; we did not identify another OPPE that had since been completed by a provider of similar competence and training to that of the thoracic surgeon.

We did not substantiate that the thoracic surgeon had a high rate of complications within the context of a high conversion rate, or that deaths resulted from quality of surgical care issues.

We substantiated that the thoracic surgeon requested that the critical care team not care for his patients. The thoracic surgeon disagreed with the critical care team's approach to post-operative fluid management and preferred to direct his patients' fluid management. We determined that he had the authority to do so under the system's policy.

We did not substantiate that a surgeon resigned because of the poor quality of care provided by the thoracic surgeon, and we did not substantiate that a fee basis surgeon was fired because he raised concerns regarding the surgeon's competence.

We did not substantiate that senior management knew of concerns about the thoracic surgeon's competence, and failed to address those concerns. No one we interviewed

[33] DUSHOM VA Memorandum, *Requirements for Peer Review of Solo Practitioners,* August 29, 2016.

could provide documentation that the Chief of Staff or System Director had been informed of concerns prior to our review.

Recommendations

1. We recommended that the System Director ensure that focused professional practice evaluations review criteria are sufficient to evaluate the privilege-specific competence for thoracic surgeons.

2. We recommended that the System Director ensure that ongoing professional practice evaluation reviews are conducted by providers with training and privileges similar to those of the provider under review.

Appendix A

Prior OIG Reports

System Reports

Healthcare Inspection – Restraint Use, Failure to Provide Care, and Communication Concerns, Bay Pines VA Healthcare System, Bay Pines, Florida

4/13/2016 | 15-01432-264

Combined Assessment Program Review of the Bay Pines VA Healthcare System, Bay Pines, Florida

8/28/2014 | 14-01292-258

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Bay Pines VA Healthcare System, Bay Pines, Florida

8/8/2014 | 14-00904-226

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9/30/2015 | 14-04598-461

Healthcare Inspection – Vascular Surgery Resident Supervision, VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska

7/9/2015 | 14-04037-404

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Appendix B

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: Date: June 27, 2017

From: Director, VA Sunshine Healthcare Network (10N8)

Subj: Healthcare Inspection— Quality of Care Concerns in Thoracic Surgery, Bay Pines VA Healthcare System, Bay Pines, Florida

To: Director, Bay Pines Office of Healthcare Inspections (54SP)
Director, Management Review Service (VHA 10E1D MRS Action)

I have reviewed and concur with the response from the Bay Pines VA Healthcare System.

Miguel H. LaPuz, M.D., MBA

Appendix C

System Director Comments

Department of Veterans Affairs

Memorandum

Date: Date: June 23, 2017

From: Director, Bay Pines VA Healthcare System (516/00)

Subj: Healthcare Inspection— Quality of Care Concerns in Thoracic Surgery, Bay Pines VA Healthcare System, Bay Pines, Florida

To: Director, VA Sunshine Healthcare Network (10N8)

1. I have reviewed and concur with the recommendations made during the Office of Inspector General's (OIG) Healthcare Inspection—Quality of Care Concerns in Thoracic Surgery, Bay Pines Healthcare System, Bay Pines, FL. Resolution actions have been accomplished on both recommendations. A plan of action was developed to include, implement, and monitor assessment of clinical competency for service–specific and procedure-specific credentialing and privileging in the Credentialing and Privileging process at Bay Pines Healthcare System.

2. Thank you to the OIG team for providing a thorough report which provided an opportunity for the healthcare system to strengthen processes and further improve the care we provide to Veterans.

Suzanne M. Klinker

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the System Director ensure that focused professional practice evaluations review criteria are sufficient to evaluate the privilege-specific competence for thoracic surgeons.

Concur

Target date for completion: August 31, 2017

System response: Focused Professional Practice Evaluations (FPPE) and Ongoing Professional Practice Evaluations (OPPE) review criteria will include privilege-specific competence assessment by a provider of similar competence and training. Inclusion of an Attestation Statement signed by a designated peer will meet the privilege-specific criteria recommended by the OIG. Designation of service-specific evaluation review has been coordinated by the Chief of Staff to perform FPPEs and OPPEs for the referenced thoracic surgeon.

Recommendation 2: We recommended that the System Director ensure that ongoing professional practice evaluation reviews are conducted by providers with training and privileges similar to those of the provider under review.

Concur

Target date for completion: August 31, 2017

System response: Compliance with the Acting Deputy Under Secretary for Health for Operations and Management' (DUSHOM) memorandum to VISN Directors, specifying that "as of August 2017, another provider with similar training and privileges should conduct FPPEs and OPPEs."

Focused Professional Practice Evaluations (FPPE) and Ongoing Professional Practice Evaluations (OPPE) review criteria will include privilege-specific competence assessment by a provider of similar competence and training. Inclusion of an Attestation Statement signed by a designated peer will ensure that privilege-specific competence is assessed.

Appendix D

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Appendix E

Report Distribution

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