DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Credentialing, Privileging, and Evaluating a Cardiologist at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana

HEALTHCARE INSPECTION | REPORT #22-00029-40 | JANUARY 17, 2023

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Richard L. Roudebush VA Medical Center (facility) in Indianapolis, Indiana, after receiving an allegation that a newly trained interventional cardiologist was hired despite poor training and references. Further allegations claimed that the interventional cardiologist provided poor quality of care to patients and that facility leaders did not respond to staff concerns regarding this provider.

The OIG did not substantiate that the interventional cardiologist was hired despite poor training and references, but identified deficiencies in the processes used to credential, privilege, and evaluate performance of the interventional cardiologist.

Facility credentialing and privileging staff verified that the interventional cardiologist had completed an interventional cardiology fellowship training program; however, due to their inexperience, they used a third-party wage verification form instead of the required verification directly from the school or program director.[1] Therefore, based on improperly verified information, facility leaders granted privileges to the interventional cardiologist. During this inspection, the OIG requested and received documentation from the interventional cardiologist indicating successful completion of the interventional cardiology fellowship program.

In conjunction with the initial required focused professional practice evaluation (FPPE), the chief of cardiology implemented a mentoring program for the newly trained interventional cardiologist.[2] During interviews, the chief of cardiology indicated that since the interventional cardiologist was newly trained, the interventional cardiologist would benefit from direct observation during procedures in the cardiac catheterization laboratory. Despite citing a need for direct observation, the OIG found that the chief of cardiology also assigned the interventional cardiologist to independently cover ST-elevation myocardial infarction (STEMI) call outside of regular working hours.[3] This required the interventional cardiologist to independently perform complex procedures. The OIG learned that the chief of cardiology removed the interventional cardiologist from afterhours STEMI call, during the initial FPPE period, after the interventional cardiologist experienced difficulty completing a STEMI case independently and another facility interventional cardiologist was called in to assist. During interviews, the chief of cardiology told

[1] OIG interviews revealed this discrepancy was related to the experience level of credentialing staff.

[2] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2012; VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. According to VHA policy, an initial FPPE is required for all providers who are requesting new privileges from a VHA facility. The initial FPPE is time-limited and may involve mentoring or proctorship by another privileged provider. The interventional cardiologist's initial FPPE period covered September 9 through December 9, 2020.

[3] "What is a STEMI?" Cleveland Clinic accessed February 23, 2022, https://my.clevelandclinic.org/health/diseases/22608-stemi-heart-attack. A STEMI is a serious type of heart attack that has a greater risk of serious complications and death…it causes a distinct pattern on an electrocardiogram."

the OIG that newly trained interventional cardiologists who "do not have enough practice…should not be put on STEMI call." However, when the OIG then asked why the interventional cardiologist was placed on afterhours STEMI call one month into employment, the chief of cardiology seemed to contradict his previous position and facility policy by stating that the applicable facility standard operating procedure was a "recommendation, not a requirement."[4]

According to the Veterans Health Administration (VHA) program office responsible for credentialing and privileging, supporting documentation is necessary to support FPPE ratings. For example, for an FPPE with less than favorable ratings, supporting documentation offers actionable data for providers to improve. Per the facility memorandum, supporting documentation for the initial FPPE must be made available to the Chair of the Executive Committee of the Medical Staff (ECMS) and others on a need-to-know basis.[5] The facility's initial FPPEs include elements that evaluate patient care, medical and clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The evaluator chooses from three rating options for each element: acceptable, marginal, and unacceptable. The chief of cardiology rated the interventional cardiologist's initial FPPE as "marginal" in medical and clinical knowledge, based on an electronic health record review of the interventional cardiologist's cases and direct observation during the initial FPPE period.[6] However, the initial FPPE did not include documentation to support the FPPE rating. When asked for documentation supporting the rating, the chief of cardiology reported no documentation of case reviews and direct observation was collected, again contradicting facility policy. According to the chief of cardiology, there is "no requirement to keep notes, other than the ones requires [sic] by the VA. My score was based on my regular personal interaction with [the interventional cardiologist]." The OIG determined that the lack of documentation to support the initial FPPE rating makes it difficult for facility leaders to identify and address specific concerns in subsequent reviews.

As a result of the marginal rating of the initial FPPE, the ECMS agreed to place the interventional cardiologist on an FPPE for Cause per the recommendation of the chief of cardiology. The process for placing a provider on an FPPE for Cause involves the service chief or management determining if a privileged provider will be placed on an FPPE for Cause based on a triggering event, defining the objective and measurable criteria for the successful completion of the FPPE for Cause, defining the evaluation period, discussing and recommending these criteria and the evaluation period with the ECMS for approval, and sharing the approved

[4] VA Veteran Health Indiana, "Cardiac Catheterization and Electrophysiology Lab Operations," Standard Operating Procedure, November 12, 2019.

[5] Facility Memorandum No. 11-22, *Professional Practice Evaluation*, December 20, 2018.

[6] The initial FPPE period covered September 9 through December 9, 2020.

criteria with the privileged provider for review and acceptance in advance of an FPPE for Cause initiation.[7]

The OIG found that the FPPE for Cause was not conducted in the required sequence.[8] Specifically, the chief of cardiology did not review the criteria for successful completion with the interventional cardiologist until half-way through the FPPE for Cause evaluation period. Additionally, the ECMS did not approve the criteria for successful completion until more than two-thirds into the evaluation period because of an identified need by the ECMS for more objective criteria for completion. The OIG determined that this delay rendered it impossible for the interventional cardiologist to clearly understand the criteria for successful completion until the evaluation period was almost over. Despite the delay in identifying objective criteria for successful completion, the interventional cardiologist successfully completed the FPPE for Cause.

The OIG did not substantiate that the interventional cardiologist provided poor quality of care to patients that resulted in adverse clinical outcomes. Despite staff complaints of clinical concerns related to the interventional cardiologist and the FPPE for Cause, the OIG did not identify instances of adverse clinical outcomes related to poor patient care. The OIG did not substantiate that facility leaders failed to act on staff members' concerns about the interventional cardiologist's practice. As a result of multiple concerns shared with facility leaders by cardiology nursing staff in May 2021, the interventional cardiologist's cardiac catheterization laboratory privileges were suspended, and a factfinding investigation was initiated in June. The factfinding report was completed on August 20, 2021, over 90 days from the interventional cardiologist's suspension.[9] The factfinding lead investigator told the OIG that pre-planned annual leave and competing workload priorities, which facility leaders were aware of from the start of the investigation, contributed to the delay. The OIG would expect more urgency in completing a factfinding related to clinical performance. Due to the lack of timeliness, facility leaders did not have information to make decisions about the interventional cardiologist's privileges. After nearly six months, the newly trained interventional cardiologist's cardiac catheterization laboratory privileges were reinstated. Days later, the interventional cardiologist resigned.[10]

While not an allegation, the OIG determined that the volume of percutaneous coronary intervention (PCI) procedures performed at the facility, a type of cardiac catheterization

[7] VHA Handbook 1100.19.

[8] The FPPE for Cause period covered December 10, 2020, through March 9, 2021.

[9] Facility Bylaws. In August 2021, the same month as the completion of the factfinding, VHA updated policy to include that factfindings be completed in a short period, from one day to three weeks, and that supervisors of factfindings must prioritize completion over other workload and responsibilities to ensure timely completion.

[10] For three months following completion of the factfinding, facility leaders sought legal consultation and collaborated with community partners to devise a plan for reinstatement of privileges and implementation of a second FPPE for Cause.

procedure used to treat a narrowed or blocked artery, was not sufficient to maintain interventional cardiologists' competence and patient safety or to provide adequate mentorship to newly trained interventional cardiologists. A facility standard operating procedure for cardiac catheterization operations utilizes recommendations of an expert consensus document that states that primary PCI procedures should be performed in institutions that complete more than 36 primary PCI procedures for STEMI per year.[11] According to procedural data for fiscal year 2021, 13 primary PCI procedures for STEMI were performed at the facility, less than half of the recommended volume.

The OIG made five recommendations to the Facility Director related to credentialing and privileging documentation verification, mentoring newly trained interventional cardiologists to take call for high-risk procedures, FPPE administration and documentation, timely completion of factfinding investigations, and assessment of PCI procedure volume and compliance with related standard operating procedures.

Comments

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

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[11] "Heart Procedures and Surgeries," American Heart Association, accessed February 17, 2022, https://www.heart.org/en/health-topics/heart-attack/treatment-of-a-heart-attack/cardiac-procedures-and-surgeries; Dehmer, "SCAI/ACC/AHA Expert Consensus Document: 2014 Update on Percutaneous Coronary Intervention Without On-Site Surgical Backup." Elliot M Antman et. al., "ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction—Executive Summary," *Circulation*. 2004; 110:588-636. Primary PCI is the reopening of an obstructed coronary artery (reperfusion) through a catheter-based treatment in a patient who presents with STEMI.

Contents

Abbreviations

EHR	electronic health record
FPPE	focused professional practice evaluation
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
PCI	percutaneous coronary intervention
STEMI	ST-elevation myocardial infarction
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Richard L. Roudebush VA Medical Center (facility) in Indianapolis, Indiana, after receiving allegations that a newly trained interventional cardiologist was hired, despite poor training and references, and provided poor quality of care to patients; and that facility leaders did not respond to staff concerns regarding the interventional cardiologist.

Background

Part of Veterans Integrated Service Network (VISN) 10, the facility is located near downtown Indianapolis, Indiana, and is classified as a Level 1A high-complexity facility.[1] The facility has a total of 209 hospital operating beds, including 159 inpatient beds and 50 domiciliary beds, and operates eight community clinics. Between October 1, 2020, and September 30, 2021, the facility served 62,787 patients with over 769,000 outpatient visits. The facility provides services to include acute inpatient medical, surgical, and rehabilitation care, as well as primary and specialized outpatient services such as comprehensive cardiac care. The facility is affiliated with academic institutions including the Indiana University School of Medicine, Marian University, and Purdue University.

Interventional Cardiology and Cardiac Catheterization

Cardiology is a subspecialty of internal medicine that focuses on heart disease prevention and management.[2] Interventional cardiology, a subspecialty of cardiology, uses non-surgical treatment of narrowed coronary arteries to improve blood flow to the heart.[3] An interventional cardiologist is a physician who completes additional training including 36 months of internal medicine residency training, 36 months of fellowship training in cardiovascular medicine, and 12 months of fellowship training in interventional cardiology.

Diagnostic and treatment cardiac catheterizations are completed by interventional cardiologists in cardiac catheterization laboratories. A diagnostic cardiac catheterization involves insertion of a thin tube into a patient's artery to permit visualization of coronary arteries and heart valves and

[1] VHA Office of Productivity, Efficiency, and Staffing. "The Facility Complexity Model classifies VHA facilities at levels 1a, 1b,1c, 2, or 3 with level 1a being the most complex and level 3 being the least complex." A level 1a facility has "high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs." The website was accessed June 2, 2022, and is an internal VA website not publicly accessible.

[2] "What is a Cardiologist?" Cleveland Clinic, accessed December 6, 2021, https://my.clevelandclinic.org/health/articles/21983-cardiologist; American College of Physicians, Subspecialties of Internal Medicine, accessed June 2, 2022. https://www.acponline.org/about-acp/about-internal-medicine/subspecialties-of-internal-medicine.

[3] "Cardiac Interventional Procedures," Catholic Health, accessed January 5, 2022, https://www.chsbuffalo.org/services/cardiac-interventional-procedures; American College of Physicians.

measurement of the pressure of blood flow in the heart. A percutaneous coronary intervention (PCI) is a type of cardiac catheterization procedure used to treat a narrowed or blocked artery.[4] Primary PCI is the strategy of taking a patient who presents with ST-elevation myocardial infarction (STEMI) (heart attack) directly to a cardiac catheterization laboratory to undergo a type of reperfusion therapy to restore blood flow in the blocked artery.[5]

Prior OIG Report

The OIG published a report concerning the facility's cardiology department in February 2020. In this report, the OIG determined that cardiologist turnover had been high at the facility resulting in six of eight cardiologists leaving the facility and cited the following reasons for leaving: hostile working environment, workload, and salary. Facility leaders credited the high turnover to internal strife, time and attendance issues, and the inability to work at the university affiliate on Veterans Health Administration (VHA) time. The OIG also determined that cardiology department and surgery service staff did not utilize the required consult process when discussing a specific cardiac surgery procedure with potential patients and maintained an unauthorized wait list of patients willing to undergo the procedure. The OIG made four recommendations to the Facility Director, with two pertaining to cardiology staffing recruitment and retention, which have been closed.[6]

Allegations and Concerns

On April 8, 2021, the OIG received a confidential complaint alleging that

- an interventional cardiologist was hired despite poor training and references,
- the interventional cardiologist provided poor quality of care to patients at the facility that resulted in adverse clinical outcomes, and
- facility leaders did not address concerns from staff related to the interventional cardiologist.[7]

[4] "Heart Procedures and Surgeries," American Heart Association, accessed February 17, 2022, https://www.heart.org/en/health-topics/heart-attack/treatment-of-a-heart-attack/cardiac-procedures-and-surgeries; During a percutaneous coronary intervention, a balloon is inserted and inflated to widen blocked areas and increase blood flow to the heart muscle; "Cardiac Catheterization," American Heart Association, accessed December 6, 2021, https:/www.heart.org/en/health-tpics/heart-attack/diagnosing-a-hear-attack/cariac-catheterization.

[5] Elliot M Antman et. al., "ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction—Executive Summary," *Circulation*. 2004; 110:588-636."

[6] VA OIG, *Healthcare Inspection—Alleged Issues in the Cardiology Department at the Richard L. Roudebush VA Medical Center, Indianapolis, Indiana*, Report No. 19-07090-90, February 27, 2020.

[7] Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, or a need for higher level of care.

During the inspection, the OIG identified additional concerns regarding

- the process used to credential and privilege the interventional cardiologist, and
- the insufficient number of procedures performed at the facility to support a safe PCI program.

During the inspection, the OIG learned of broader, ongoing concerns pertaining to the cardiology department and its leadership, shared a summary of the issues with the Facility Director, and initiated another healthcare inspection in December 2021 to review the concerns. The chief of cardiology was reassigned from the leadership role to a staff interventional cardiologist position in late November.

Scope and Methodology

The OIG initiated the inspection on October 7, 2021, and conducted a virtual site visit the week of November 15, 2021. The OIG interviewed the complainant, facility leaders, and facility staff from credentialing and privileging, quality management, and cardiology.

The OIG reviewed relevant VHA directives, facility policies, organizational charts, facility committee charters, meeting minutes, credentialing and privileging documents, and quality and safety reviews. The OIG also reviewed select electronic health records (EHRs) from August 21, 2020, through October 29, 2021, the period that the interventional cardiologist was employed by the facility.

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

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Inspection Results

1. Credentialing and Privileging of the Cardiologist

The OIG did not substantiate that the interventional cardiologist was hired despite poor training and references. The interventional cardiologist completed an accredited fellowship program and references provided were satisfactory. However, the OIG found deficiencies in the processes used to credential, privilege, and evaluate performance of the interventional cardiologist.

Credentialing and Privileging

The OIG determined that credentialing and privileging staff failed to verify that the interventional cardiologist had completed a fellowship program. The OIG determined that the Facility Director granted the interventional cardiologist privileges based on erroneous credentialing information.

Credentialing is the process of screening and evaluating qualifications and other credentials.[8] According to VHA policy, credentialing and privileging staff verify a provider's professional education, training, references, licensure, and skill. VHA requires that the facility director ensures a provider's credentialing information related to education and training is verified from primary sources—directly from a school or program director—prior to initial appointment to medical staff.[9]

The OIG reviewed the credentialing actions performed by credentialing and privileging staff and found that while the interventional cardiologist's education and references were verified, the interventional cardiology fellowship training was verified with a third-party wage verification form instead of the required primary source verification directly from the school or program director. When asked about the failure to confirm completion of the interventional cardiology fellowship, the chief of credentialing and privileging cited credentialing and privileging staff's lack of experience and identified the issue as an opportunity for improvement.[10] As a result of the failure to verify completion of the fellowship, facility leaders did not have proof of the provider's competency in interventional cardiology, a key component needed for granting privileges to perform interventional cardiology procedures.

[8] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2012; VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.

[9] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2012. This handbook was in effect at the time of the events discussed in this report until it was partially rescinded and replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. Both contain the same or similar language regarding the credentialing process.

[10] The OIG obtained evidence indicating interventional cardiology fellowship program completion directly from the interventional cardiologist.

According to VHA, the privileging process ensures providers are clinically competent to independently provide patient care. Clinical privileges are based on evidence of current competence supported by documentation in the credentialing record. Privileges are recommended by service chiefs and the Executive Committee of the Medical Staff (ECMS) and approved by facility directors.

The OIG found that in response to the interventional cardiologist's request for clinical privileges, the chief of cardiology recommended the interventional cardiologist for cardiology privileges, including invasive cardiology privileges based on the unverified fellowship program information contained in the provider's credentialing record. In essence, the chief of cardiology assumed that the interventional cardiologist had completed the fellowship program. The Facility Director approved the privileges as recommended by the service chief and ECMS on August 21, 2020.

The OIG concluded that credentialing and privileging staff failed to ensure a complete and accurate credentialing and privileging file, which was then used by facility leaders to grant privileges. Although the OIG received documentation supporting the interventional cardiologist's completion of the interventional cardiology fellowship program, had the interventional cardiologist not completed the interventional cardiology fellowship training, facility leaders would have granted privileges to an insufficiently trained provider to perform procedures on patients.

Mentoring During the Initial Focused Professional Practice Evaluation

The OIG found that, although a plan was in place to mentor the interventional cardiologist during the initial focused professional practice evaluation (FPPE) period, the newly trained interventional cardiologist was assigned to cover off-shift call to perform complex procedures independently.[11] Additionally, FPPE supporting documentation was not reflective of the clinical concerns that prompted a subsequent FPPE for Cause.

According to VHA policy, an initial FPPE is required for all providers who are requesting new privileges from a VHA facility. The initial FPPE is time-limited and may involve mentoring or proctorship by another privileged provider.[12] A facility standard operating procedure (SOP) adopts recommendations from medical literature that newly trained interventional cardiologists

[11] The initial FPPE period covered September 9 through December 9, 2020. Facility Memorandum No. 11-72, "Call Schedules," January 17, 2019. The act of being on-call identifies individuals who should be called into the facility for specific services as needed.

[12] VHA Handbook 1100.19.

should be mentored by more experienced providers until determined that they are safe to independently perform PCIs, which includes scheduled diagnostic and STEMI procedures.[13]

VHA policy does not explicitly state that documentation must be included to support FPPE ratings. According to the VHA program office responsible for credentialing and privileging, such supporting documentation is necessary.[14] For example, for an FPPE with less than favorable ratings, documentation offers actionable data for providers to improve. Per the facility memorandum, supporting documentation for the initial FPPE must be made available to the Chair of ECMS and others on a need-to-know basis.[15] The facility's initial FPPEs include elements that evaluate patient care, medical and clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The evaluator chooses from three rating options for each element: acceptable, marginal, and unacceptable.[16]

Successful completion of the initial FPPE results in continued monitoring of the provider's quality of care through an ongoing professional practice evaluation.[17] If the initial FPPE identifies a need for improvement, an FPPE for Cause can be initiated.[18]

The OIG found that the chief of cardiology reported coordinating a mentorship plan that included

- a facility cardiologist's review of the interventional cardiologist's echocardiography interpretations with mentorship based on review, and
- a facility interventional cardiologist's active supervision and mentorship of the interventional cardiologist in the cardiac catheterization laboratory one and a half days per week.

During an interview, the Chief of Quality, Safety, and Value explained to the OIG that the purpose of direct observation is to mitigate death and significant morbidity and should occur in the hard cases [such as STEMI cases]. Additionally, the Chief of Quality, Safety, and Value stated that diagnostic catheterization procedures do not require direct observation. Despite planning to mentor the interventional cardiologist, one month into the initial FPPE period, the

[13] Gregory J. Dehmer, et al., "SCAI/ACC/AHA Expert Consensus Document: 2014 Update on Percutaneous Coronary Intervention Without On-Site Surgical Backup," *American Heart Association Circulation* 129, no. 4 (June 17, 2014):2610-2626; Elliot M Antman et. al., "ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction—Executive Summary," Circulation. 2004; 110:588-636; VA Veteran Health Indiana, "Cardiac Catheterization and Electrophysiology Lab Operations," Standard Operating Procedure, November 12, 2019.

[14] VHA Handbook 1100.19.

[15] Facility Memorandum No. 11-22, *Professional Practice Evaluation*, December 20, 2018.

[16] Facility Memorandum No. 11-22.

[17] VHA Handbook 1100.19.

[18] VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018.

chief of cardiology assigned the interventional cardiologist to cover off-tour STEMI call independently, without mentoring by a facility interventional cardiologist.

The OIG learned through documents provided by the facility and OIG interviews with facility leaders that the interventional cardiologist was removed from STEMI call by the chief of cardiology after the interventional cardiologist experienced difficulty completing a STEMI case independently and another interventional cardiologist who was off-tour and off-campus was called in to assist. In an OIG interview, the chief of cardiology noted that newly trained interventional cardiologists who "do not have enough practice…should not be put on STEMI call." When asked why the interventional cardiologist was placed on afterhours STEMI call one month into employment, despite the facility's SOP containing adopted medical literature recommendations pertaining to STEMI call and the chief of cardiology's testimony, the chief of cardiology reported that the facility SOP contained a "recommendation, not a requirement," and claimed that placing newly trained interventional cardiologists on STEMI calls with a senior physician as backup was industry standard.

The OIG determined that the chief of cardiology assigned the interventional cardiologist to cover off-tour STEMI call independently prior to the interventional cardiologist demonstrating the ability to complete complex cases independently.

At completion of the initial FPPE, the chief of cardiology presented the results to ECMS and recommended that the interventional cardiologist be placed on an FPPE for Cause as an opportunity for further mentoring. As the evaluator, the chief of cardiology rated the interventional cardiologist's initial FPPE as "marginal" in medical and clinical knowledge, based on an EHR review of the interventional cardiologist's cases and direct observation during the initial FPPE period. Contrary to the SOP, the chief of cardiology reported that no documentation of case reviews and direct observation was collected, and that there is "no requirement to keep notes, other than the ones requested by the VA. My score was based on my regular personal interaction with [the interventional cardiologist]." The chief of cardiology also rated the interventional cardiologist as marginal in interpersonal and communication skills after documented interpersonal conflict with a facility interventional cardiologist.

The OIG determined that the lack of documentation to support the initial FPPE rating raised questions about the objectivity of the final determination, making it difficult to identify a specific clinical competency concern to support the subsequent FPPE for Cause.

FPPE for Cause

The OIG found the FPPE for Cause was not conducted in the sequence required by VHA policy, which limited the interventional cardiologist's understanding of the criteria being evaluated.

According to VHA policy, facility leaders may initiate an FPPE for Cause for a privileged provider as an "opportunity to improve."[19] The facility's Professional Practice Evaluation Memorandum lists clinical scenarios that may trigger an FPPE for Cause, including quality of care concerns.[20] The process for placing a provider on an FPPE for Cause involves the service chief or management

- making the determination if a privileged provider will be placed on an FPPE for Cause based on a triggering event,
- defining the objective and measurable criteria for the successful completion of the FPPE for Cause,
- defining the FPPE for Cause evaluation period,
- discussing and recommending these criteria and evaluation period with the ECMS Committee for approval, and
- sharing the criteria with the privileged provider in advance of an FPPE for Cause initiation for review and acceptance.

As the evaluator of the initial FPPE, the chief of cardiology rated the interventional cardiologist as "marginal" in medical and clinical knowledge based on an EHR review of the interventional cardiologist's cases and direct observation during the initial FPPE period. More than two months after the initial FPPE ended, the chief of cardiology presented the results to ECMS and recommended that the interventional cardiologist be placed on an FPPE for Cause as an opportunity for further mentoring.[21] As a result, the chief of cardiology drafted an FPPE for Cause that included objective criteria and a review period, and backdated it to begin immediately following the completion of the initial FPPE. The chief of cardiology reviewed the criteria with the interventional cardiologist half-way through the FPPE for Cause review period. The ECMS did not approve the criteria until more than two-thirds into the review period because of the identified need for more objective measures for completion rendering it impossible for the interventional cardiologist to clearly understand the evaluation process until it was almost over (see figure 1). Despite the facility's delay in identifying objective criteria for successful completion, the interventional cardiologist successfully completed the objective measures passing the FPPE for Cause and was placed on an ongoing professional practice evaluation.

[19] VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018.

[20] Facility Memorandum No. 11-22.

[21] The FPPE for Cause period covered December 10, 2020, through March 9, 2021.

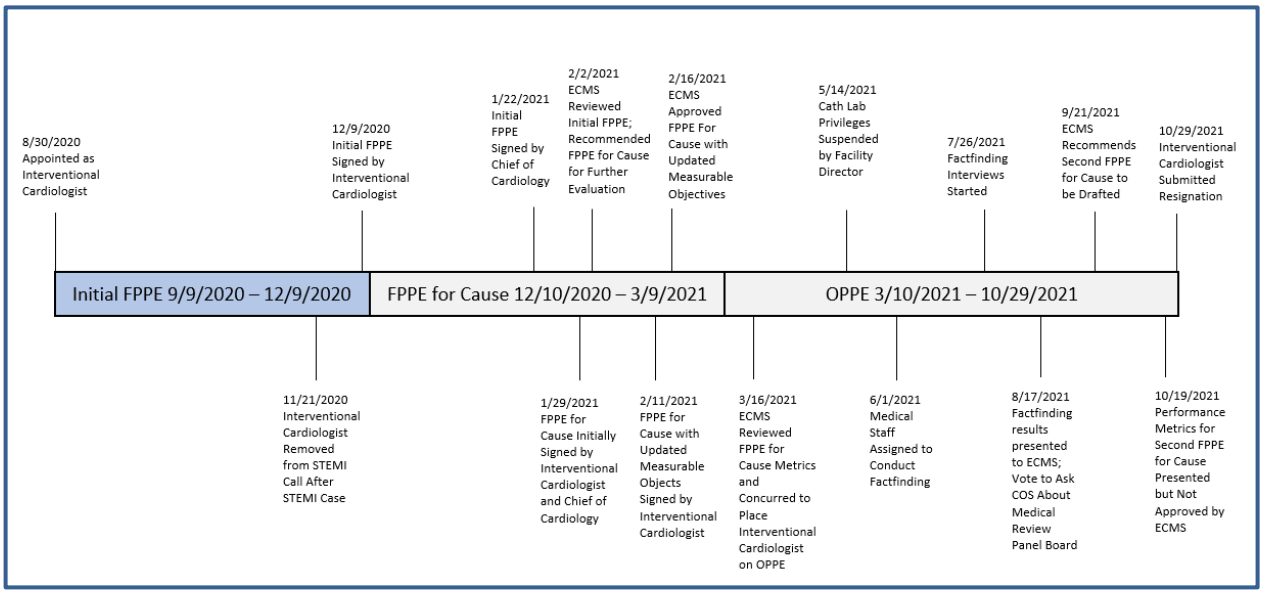

Figure 1. *Timeline of key events during the interventional cardiologist's employment from August 30, 2020, to October 29, 2021.*
Source: VA OIG analysis of facility-provided documents.

2. Alleged Poor Quality of Care that Resulted in Adverse Clinical Outcomes

The OIG did not substantiate that the interventional cardiologist provided poor quality of care to patients that resulted in adverse clinical outcomes. Despite staff complaints of clinical concerns related to the interventional cardiologist, the OIG did not identify instances of adverse clinical outcomes related to poor patient care.

When asked by the OIG, the complainant did not provide patient names impacted by the interventional cardiologist's alleged poor care. During OIG interviews, facility physician leaders and staff cardiologists stated they were not aware of adverse clinical outcomes related to the interventional cardiologist's care. Quality management staff reported receiving facility staff complaints about the interventional cardiologist; however, none were specific to adverse clinical outcomes.

Multiple cardiac catheterization laboratory staff were asked about any adverse clinical outcomes related to the interventional cardiologist's performance. Although no adverse clinical outcome examples were provided, the staff reported concern for the interventional cardiologist's management of a particular case during the interventional cardiologist's initial FPPE period.

This case involved a patient who was experiencing a STEMI during an off-tour shift for which the interventional cardiologist was on-call independently.[22] When the patient began to experience complications, nursing staffed called in another interventional cardiologist. Although the procedure duration exceeded the facility's timeliness goal, no adverse events were documented in the EHR.[23] The case was not reported as an invasive cardiology complication—a metric monitored by the chief of cardiology—and, in an OIG interview, the chief of cardiology confirmed that this case did not meet criteria to be considered a complication. The OIG team concurred that this case did not result in an adverse clinical outcome.

In addition to the reported STEMI case, through review of cardiology department minutes, the OIG learned that the interventional cardiologist was involved in a complication during a procedure. The minutes noted that the complication did not result in an adverse clinical outcome. The OIG team reviewed the case and confirmed that the complication did not result in an adverse clinical outcome.

The OIG identified three patient safety events involving the interventional cardiologist that were reported to the patient safety manager. The OIG reviewed EHRs for the three cases and determined that no adverse clinical outcomes occurred as a result of the patient safety events. Additionally, the OIG found that the patient safety manager appropriately categorized and acted upon the reports.

The OIG reviewed the STEMI case, a single reported cardiac catheterization laboratory complication, and identified patient safety events that involved the interventional cardiologist and did not substantiate that the interventional cardiologist provided poor quality of care to patients at the facility that resulted in adverse clinical outcomes.

3. Facility Leaders' Response to Staff Concerns

The OIG did not substantiate that facility leaders failed to act on staff members' concerns about the interventional cardiologist's practice. Facility leaders conducted two factfinding investigations; however, one factfinding review began over two months after the interventional cardiologist's privileges were suspended.

In the interest of patient safety, a chief of staff may recommend that a facility director consider suspending a provider's privileges and conducting an administrative investigation such as a

[22] "What is a STEMI?" Cleveland Clinic accessed February 23, 2022, https://my.clevelandclinic.org/health/diseases/22608-stemi-heart-attack. A STEMI is a type of heart attack that "has a greater risk of serious complications and death…it causes a distinct pattern on an electrocardiogram."

[23] Dehmer, "SCAI/ACC/AHA Expert Consensus Document: 2014 Update on Percutaneous Coronary Intervention Without On-Site Surgical Backup." The facility goal for inpatients experiencing a STEMI is 90 minutes from EKG to inflation of a balloon in the cardiac catheterization laboratory. Elliot M Antman et. al., "ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction—Executive Summary," Circulation. 2004; 110:588-636.

factfinding review.[24] Suspension of privileges includes prohibiting the provider from performing some or all procedures.[25]

In response to reported concerns about the interventional cardiologist underestimating contrast use in the catheterization laboratory in February 2021, facility leaders conducted a factfinding investigation led by the Associate Chief of Staff for Education and a leader from the radiology service. The investigation focused on eight allegations related to the volume of contrast used by the interventional cardiologist and attempts made to adjust contrast volume documented in the EHR. The factfinding did not substantiate any of the eight allegations.

In May 2021, cardiac catheterization laboratory nursing leaders shared with the chief of procedural medicine multiple staff allegations related to the interventional cardiologist. The OIG found that many of these concerns related to professionalism and interpersonal relationships and none identified patient cases in which adverse clinical outcomes resulted.

The OIG learned through facility committee meeting minutes that the Facility Director suspended the interventional cardiologist's cardiac catheterization privileges on May 14, 2021, as a result of nursing staff concerns related to conduct and clinical competency, but allowed general cardiology privileges to be maintained.

According to facility documents, the ECMS initiated an investigation of nursing staff concerns to the Associate Chief of Staff for Education on June 1, 2021. The Associate Chief of Staff for Education conducted a factfinding review of nine allegations, as seen in Appendix A, involving the interventional cardiologist's clinical performance and professional conduct in the cardiac catheterization laboratory.

Interviews for the factfinding review began July 26, 2021, over two months after the interventional cardiologist's privileges were suspended.[26] In communications with the OIG, the Associate Chief of Staff for Education cited a concurrent investigation on another provider as one reason for the delay, which facility leaders were aware of from the start of the investigation. The Associate Chief of Education also noted pre-planned annual leave and a high level of responsibility at that time of year in an education role as additional reasons for the delay. The factfinding report was completed on August 20, 2021, over 90-days from the interventional cardiologist's suspension. The final report substantiated eight of the nine allegations.

Based on the factfinding outcome, the ECMS voted on September 21, 2021, to place the interventional cardiologist on a second FPPE for Cause. The ECMS approved a Chief of Staff recommendation for a "sub-group," outside the ECMS to develop the specific parameters and

[24] Facility Bylaws.

[25] Facility Bylaws.

[26] In August 2021, the same month as the completion of the factfinding, VHA updated policy to include that factfindings be completed in a short period, from one day to three weeks, and that supervisors of factfindings must prioritize completion over other workload and responsibilities to ensure timely completion.

benchmarks of the second FPPE for Cause. In order to be able to place the interventional cardiologist on an FPPE for Cause, the Facility Director reinstated cardiac catheterization laboratory privileges on October 28, 2021. The second FPPE for Cause was sent to ECMS members for a vote on October 22, 2021, and included monitoring the interventional cardiologist for a 90-day period. The OIG learned the interventional cardiologist resigned, effective on October 29, 2021, and never signed the second FPPE for Cause. The period between the suspension and reinstatement of cardiac catheterization laboratory privileges spanned almost six months, during which the interventional cardiologist was unable to refine interventional cardiology catheterization laboratory procedural skills.[27]

As a result of nursing staff concerns, the interventional cardiologist's cardiac catheterization laboratory privileges were suspended and remained suspended during the factfinding. The OIG would expect more urgency in completing a factfinding related to clinical performance. The newly trained interventional cardiologist's cardiac catheterization laboratory privileges were not reinstated for a period of almost six months before resigning. Due to the lack of timeliness, facility leaders did not have timely information to make decisions about the interventional cardiologist's privileges.

4. Low Volume of Percutaneous Coronary Intervention Program

The OIG determined that the patient volume in the facility's PCI program was not sufficient to maintain interventional cardiologists' competence with primary PCI procedures and patient safety or to provide adequate mentorship to newly trained interventional cardiologists.

The facility's SOP for cardiac catheterization operations outlines daily operations to "ensure quality, safety, efficient patient flow, and define the scope of operational responsibilities within the department."[28] The SOP instructs staff in the department to utilize the recommendations of an expert consensus document as the basis of the department's practice guidelines on topics including personnel and facility requirements for PCI programs without facility on-site cardiac surgery backup. Specific to primary PCIs

[27] For three months following completion of the factfinding, facility leaders sought legal consultation. Additionally, the Chief of Staff reported collaborating with community partners during this time to devise a plan for reinstatement of privileges and implementation of a second FPPE for Cause.

[28] VA Veteran Health Indiana, "Cardiac Catheterization and Electrophysiology Lab Operations."

> Ideally, these procedures should be performed in institutions that perform more than 200 elective PCIs per year ***and more than 36 primary PCI procedures for STEMI per year*** [emphasis added by OIG].[29]

According to procedural data for fiscal year 2021, the facility met the more than 200 elective PCI volume recommendation.[30] Conversely, thirteen primary PCI procedures for STEMI were performed at the facility in fiscal year 2021; less than half of the recommended volume.

In OIG interviews, the Chief of Staff and the chief of cardiology shared concerns that the volume of procedures available in the cardiac catheterization laboratory impacted the interventional cardiologist's ability to improve skills.

The OIG determined that the facility met the volume recommendation established in their SOP for elective PCI procedures; however, less than half of the recommended PCI for STEMI procedures were performed in fiscal year 2021. A newly trained interventional cardiologist would not have the STEMI procedure volume required to improve skills, which would directly impact patient safety.

Conclusion

The OIG did not substantiate that the interventional cardiologist was hired despite poor training and references. However, the OIG found that credentialing and privileging staff failed to verify that the interventional cardiologist had completed a fellowship program and that facility leaders granted the interventional cardiologist privileges to perform related procedures without documented competence. The OIG recognized that improper credentialing of a provider could lead facility leaders to privilege an insufficiently trained provider to perform procedures on patients.

The OIG found that, although a plan was in place to mentor the interventional cardiologist, the newly trained physician was assigned to cover off-tour STEMI call to perform complex procedures independently. The initial FPPE did not include documentation to support the clinical concerns that prompted a subsequent FPPE for Cause. Additionally, a subsequent FPPE for Cause was not conducted in sequence and did not ensure the interventional cardiologist was knowledgeable about evaluation criteria prior to initiation.

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[29] Elliot M Antman et. al., "ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction—Executive Summary," *Circulation*. 2004; 110:588-636. Primary PCI is the reopening of an obstructed coronary artery (reperfusion) through a catheter-based treatment in a patient who presents with STEMI. Gregory J. Dehmer, et al., "SCAI/ACC/AHA Expert Consensus Document: 2014 Update on Percutaneous Coronary Intervention Without On-Site Surgical Backup."

[30] Sunil V. Rao et. al., "2021 ACC Expert Consensus Decision Pathway on Same-Day Discharge After Percutaneous Coronary Intervention: A Report of the American College of Cardiology Solution Set Oversight Committee," *Journal of the American College of Cardiology* 77, no.6 (2021):811–825. Elective PCI is a procedure performed on an outpatient, non-urgent, basis without significant risk of infarction or death.

The OIG reviewed the interventional cardiologist's FPPEs, the STEMI case, the single reported cardiac catheterization laboratory complication, and identified cases that involved the interventional cardiologist, and did not substantiate that the interventional cardiologist provided poor quality of care to patients at the facility that resulted in adverse clinical outcomes.

The OIG did not substantiate that facility leaders failed to act on staff member concerns about the interventional cardiologist's practice. However, the OIG found that a factfinding review began over two months after the interventional cardiologist's privileges were suspended.

The OIG would expect more urgency in completing a factfinding related to clinical performance. The newly trained interventional cardiologist's cardiac catheterization laboratory privileges were not reinstated for a period of almost six months before resigning. Due to the lack of urgency, facility leaders did not have timely information to make decisions about the interventional cardiologist's privileges. As a result of facility leaders' actions, the newly trained interventional cardiologist was not mentored as required to improve clinical practice and was not privileged in the cardiac catheter laboratory for almost six months.

The volume in the facility's PCI program was not adequate to maintain interventional cardiologists' competence and patient safety, or to provide adequate mentorship to newly trained interventional cardiologists. The OIG determined that the facility met the volume recommendation established in the SOP for elective PCI procedures; however, less than half of the recommended PCI for STEMI procedures were performed in fiscal year 2021. A newly trained interventional cardiologist did not have the STEMI procedure volume required to improve skills.

The OIG made five recommendations.

Recommendations 1–5

1. The Richard L. Roudebush VA Medical Center Director reviews credentialing and privileging practices to identify and address staff training deficiencies in verifying documentation required for credentialing and privileging of new providers.

2. The Richard L. Roudebush VA Medical Center Director ensures that newly trained interventional cardiologists are mentored by experienced physicians until it is determined that their skills, judgement, and outcomes are deemed safe to be placed on independent call for high-risk procedures as required by the facility standard operating procedure.

3. The Richard L. Roudebush VA Medical Center Director ensures that staff conduct and document focused professional practice evaluations as required by the Veterans Health Administration.

4. The Richard L. Roudebush VA Medical Center Director ensures timely completion of factfinding reviews to promptly identify and address system vulnerabilities.

5. The Richard L. Roudebush VA Medical Center Director assesses the volume of percutaneous coronary intervention for ST-elevation myocardial infarction procedures performed in the cardiac catheterization laboratory and determines a path forward to comply with the facility's standard operating procedures.

Appendix A

Table A.1. Results of Factfinding on Nursing Staff Allegations

Allegations Regarding Interventional Cardiologist	Finding
1. Unable to safely and fully function as an independent interventional cardiologist	Substantiated
2. Used unauthorized medical material to apply pressure to upper extremity catheterization sites when directed not to	Substantiated
3. Created a hostile work environment in the catheterization laboratory	Substantiated
4. Failed to follow supervisor's direct instructions while being proctored in the catheterization laboratory	Substantiated
5. Created undue patient care delays by leaving the catheterization laboratory when a patient was positioned and ready for the procedure to begin	Substantiated
6. Answered multiple phone calls over Bluetooth while in the middle of performing interventional catheterization laboratory procedures	Substantiated
7. Would frequently ask catheterization laboratory support staff for confirmation of various technical aspects during interventional catheterization laboratory procedures	Substantiated
8. Requested only male catheterization laboratory staff to pull sheaths and apply site pressure	Substantiated
9. Failed to disclose complications that occurred during catheterization laboratory procedures to patients and/or family members	Not Substantiated

Source: OIG analysis of factfinding documentation.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 22, 2022

From: Network Director, VISN 10 (10N10)

Subj: Healthcare Inspection—Deficiencies in Credentialing, Privileging, and Evaluating a Cardiologist at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana

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

1. I have reviewed the draft report of the Healthcare Inspection – Deficiencies in Credentialing, Privileging, and Evaluating a Cardiologist at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana.
2. I concur with the responses and action plans submitted by the Richard L. Roudebush VA Medical Center Director.
3. Thank you for the opportunity to respond to this report.

(*Original signed by*:)

Laura E. Ruzick, FACHE

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 22, 2022

From: Director, Richard L. Roudebush VA Medical Center (583)

Subj: Healthcare Inspection—Deficiencies in Credentialing, Privileging, and Evaluating a Cardiologist at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana

To: Director, VA Healthcare System Serving Ohio, Indiana and Michigan (10N10)

1. The Richard L. Roudebush VA Medical Center is committed to quality health care and continues to build an organization focused on improving patient safety. I reviewed the draft report and concur with the action plan as submitted.

2. If you have any additional questions, please contact the Chief, Quality, Safety, and Value (QSV).

(*Original signed by*:)

Michael E. Hershman, MHA, FACHE

Facility Director Response

Recommendation 1

The Richard L. Roudebush VA Medical Center Director reviews credentialing and privileging practices to identify and address staff training deficiencies in verifying documentation required for credentialing and privileging of new providers.

Concur.

Target date for completion: June 30, 2023

Director Comments

The Richard L. Roudebush VA Medical Center credentialing staff practices primary source verification for all providers within the system per VHA Directive 1100.20, Credentialing & Privileging. In the case of this provider, credentialing was unable to obtain primary source verification of the provider's fellowship, therefore a secondary source was utilized. Email attempts for primary source verification were performed on 8/3/20, 8/4/20, and 8/11/20; fax attempts on 8/3/20 and 8/10/20.

According to VHA Handbook 1100.20 regarding good faith verification:

i. Good Faith Effort. Good faith effort is the reasonable attempt to obtain primary source documentation. A minimum of two efforts to obtain primary source documentation must be made with supporting written documentation. These efforts can be documented in the form of a report of contact, in lieu of the document sought. If a Good Faith Effort has been made and documented, but no primary source documents can be obtained, the VA medical facility Credentialing Specialist must then obtain verification through a secondary source. NOTE: Good Faith Efforts may never be used for verification of licensure, registration, or certification obtained within the United States, including Puerto Rico. Verifications of these credentials may only be from the primary source.

The good faith effort for the provider's professional training was incorrectly documented using the wage verification location rather than a report of contact. All Credentialing staff were re-educated regarding the importance of using correct documentation process when primary source verification of professional training is unable to be obtained. To monitor sustainment, weekly huddles in Credentialing service will include any issues with obtaining primary source verification. Audits will also be performed for 6 months to confirm primary source verification is completed and documented when credentialing and privileging new providers in accordance with VHA Directive 1100.20.

Recommendation 2

The Richard L. Roudebush VA Medical Center Director ensures that newly trained interventional cardiologists are mentored by experienced physicians until it is determined that their skills, judgement, and outcomes are deemed safe to be placed on independent call for high-risk procedures as required by facility standard operating procedure.

Concur.

Target date for completion: June 30, 2023

Director Comments

The Richard L. Roudebush VA Medical Center Director ensures that newly trained interventional cardiologists are mentored by experienced physicians until it is determined that their skills, judgement, and outcomes are deemed safe to be placed on independent call for high-risk procedures in accordance with VHA Directive 1100.20. Licensed independent practitioners are only credentialed and privileged after a rigorous residency and fellowship in their chosen specialty. This is administered by the American College of Graduate Medical Education (ACGME) in conjunction with the American Board of Medical Specialties (ABMS) covering the entirety of training and compliance with the ABMS standards.

After this process and with onboarding of new physicians, VHA mandated 90-day FPPE is always performed. When deficiencies are identified in performance, appropriate action will be taken. It is possible that a practitioner can pass through the final safeguard of ACGME requirement fulfillment without being competent; an FPPE for cause was initiated in this case to quantify this deficiency. The FPPE is the approved mechanism by Directive for the monitoring of newly appointed practitioners.

The facility standard operating procedure quotes the 'SCAI/ACC/AHA Expert Consensus Document: 2014 Update on Percutaneous Coronary Intervention Without On-Site Surgical Backup' from the journal Circulation which recommends greater than 36 primary PCI procedures but states 'individual operator volume is but one of several factors that should be considered in assessing operator competence, which include lifetime experience, institutional volume, the operator's other cardiovascular interventions and quality assessment of the operator's ongoing performance.' These quality assessments are ongoing, first as an FPPE and then as an OPPE [ongoing professional practice evaluation].

The Executive Committee of the Medical Staff will monitor FPPE completion for the next 6 months as a monitor for provider competency.

Recommendation 3

The Richard L. Roudebush VA Medical Center Director ensures that staff conduct and document focused professional practice evaluations as required by Veterans Health Administration.

Concur.

Target date for completion: June 30, 2023

Director Comments

The Richard L. Roudebush VA Medical Center concurs FPPE documentation is critical to ensure providers deliver safe, quality care to Veterans. The Chief of Staff through the Executive Committee of the Medical Staff discusses FPPEs and OPPEs on a bi-monthly basis. Audits will be performed for 6 months to confirm that FPPEs were conducted and documented in accordance with VHA Handbook 1100.20.

Recommendation 4

The Richard L. Roudebush VA Medical Center Director ensures timely completion of factfinding reviews to promptly identify and address system vulnerabilities.

Concur.

Target date for completion: June 30, 2023

Director Comments

The Richard L. Roudebush VA Medical Center Director concurs that fact findings should be expediently performed. In this case, there were 3 overlapping fact findings, an administrative investigative board, another OIG investigation, and a national program office review within a year of this investigation. Additionally, key witnesses were not available that were necessary to provide assurance that all sides were being fairly represented.

The facility does agree that fact findings can lead to valuable insights into system and provider vulnerabilities. When this occurs, the data is acted upon immediately, while the factfinding may still be ongoing. In this case, the fact finding was initiated to collect information for potential further personnel actions at the direction of the Medical Center Director and Office of General Counsel. However, the system vulnerabilities had been a subject of discussion both internally and externally and were actively being addressed.

The importance of the team members performing an investigation of this nature cannot be over-emphasized as the results can have significant effects on the medical practice and licensure of the individual and should not be rushed. Experienced physicians who are knowledgeable regarding the specific practice of medicine are required, especially when an ACGME accredited program

has deemed the provider competent. In this case, a more expedient fact finding would not have included a physician knowledgeable regarding the clinical issues and would have missed key interviews, leading to potentially difficult personnel actions that could be legally contested.

The Medical Center Director does and will monitor fact findings occurring within the facility for timeliness and system vulnerabilities. While fact findings occur, new knowledge regarding system vulnerabilities will be prioritized for immediate action.

The time to completion of fact findings related to clinical care concerns will be monitored and reported to the OIG for the next 6 months. Without specific directives specifying the amount of time fact findings should take, this recommendation will be closed in consultation with OIG once the data is collected for the next 6 months.

Recommendation 5

The Richard L. Roudebush VA Medical Center Director assesses the volume of percutaneous coronary intervention for ST-elevation myocardial infarction procedures performed in the cardiac catheterization laboratory and determines a path forward to comply with facility standard operating procedures.

Concur.

Target date for completion: June 30, 2023

Director Comments

The stabilization of the department with a new chief and renewed relationships with the academic affiliates has led to experienced interventional cardiologists who perform complex procedures to be placed within the Richard L. Roudebush VA Medical Center. These cardiologists will participate in ‘STEMI call’, which will expose them to all the STEMIs present in four hospitals across the academic campus. This will provide the volume of STEMIs necessary to maintain provider competence and comply with facility standard operating procedures.

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