# Department of Veterans Affairs
# Office of Inspector General

# Healthcare Inspection

# Provider Privileging and Delayed Patient Care VA Connecticut Healthcare System West Haven, Connecticut

Report No. 11-01733-208

June 28, 2011

VA Office of Inspector General
Washington, DC 20420

**To Report Suspected Wrongdoing in VA Programs and Operations:**
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# Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections (OHI) conducted a review to determine the validity of allegations regarding a service's administrative practice at the VA Connecticut Healthcare System West Haven Campus, West Haven, CT.

The complainant alleged that the service chief did not recently provide direct patient care, did not meet the requirements for physician re-privileging, and intentionally delayed patient care based on the assigned provider.

We did not substantiate that the service chief:

- Did not provide recent direct patient care or meet the requirements for re-privileging; however, VA Connecticut Healthcare System leadership is taking steps to clarify the requirements for documentation of clinical competence for privileging based on the OHI *Combined Assessment Program Review of the VA Connecticut Healthcare System West Haven, Connecticut*, Report Number 10-03090-87, February 14, 2011.
- Delayed patient care based on the assigned provider.

The VISN and System Directors concurred with our findings. We made no recommendations.

**DEPARTMENT OF VETERANS AFFAIRS**
**Office of Inspector General**
**Washington, DC 20420**

**TO:** Director, VA New England Healthcare System (10N1)

**SUBJECT:** Healthcare Inspection – Provider Privileging and Delayed Patient Care, VA Connecticut Healthcare System, West Haven, Connecticut

## Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) reviewed allegations regarding a service's administrative practice at the VA Connecticut Healthcare System West Haven Campus (facility) West Haven, CT. The purpose of the inspection was to determine if the allegations had merit.

## Background

The VA Connecticut Healthcare System has two campuses located in Newington and West Haven, CT. The facility is part of Veterans Integrated Service Network (VISN) 1 and serves a veteran population of more than 253,000 in Connecticut and southern New England. The 230-bed facility provides comprehensive healthcare through inpatient and outpatient services in medicine, surgery, psychiatry, specialty areas, physical medicine and rehabilitation, neurology, oncology, dentistry, and long-term care services.

In February 2011, a complainant contacted OIG's Hotline Division regarding a service chief's administrative practices. The complainant alleged that the facility service chief:

- Did not provide recent direct patient care or meet the requirements for re-privileging.[1]
- Delayed patient care based on the assigned provider.

## Scope and Methodology

While onsite April 5–6, 2011, we interviewed facility leaders and staff pertinent to the allegations. Additionally, we conducted telephone interviews with staff reported as

[1] Re-privileging is the process of granting a physician continuing permission to practice a specialty within a health care setting for a specified period of time.

having knowledge of the allegations. We reviewed relevant facility and Veterans Health Administration policies and related documents including patient care assignments, performance improvement (PI) data, and physician credentialing and privileging files.

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: Direct Patient Care and Physician Re-Privileging Requirements

We did not substantiate that the service chief did not recently provide direct patient care and therefore, did not meet a requirement for physician re-privileging. We reviewed the service chief's credentialing and privileging folder as well as patient assignments within the service for the previous 18-month period. OHI *Combined Assessment Program Review of the VA Connecticut Healthcare System West Haven, Connecticut*, Report Number 10-03090-87, February 14, 2011, recommended physician privileging documentation revision. Although the service chief did not have documentation of requirements for core privileges, those interviewed reported that the service chief is regularly present in patient care areas and is actively involved in direct patient care and supervision of resident physicians. Facility leadership is taking steps to clarify requirements for documentation of clinical competence for re-privileging to ensure all providers have appropriate documentation to warrant re-privileging.

### Issue 2: Delays in Patient Care

We did not substantiate that the service chief delayed patient care based on provider assignments. We interviewed staff and reviewed PI data regarding timeliness of care over the previous 18 months. Staff stated that the service chief did change the order of patient care assignments based on the needs of the patient and staff involved in the care. Staff interviewed could not recall any change that targeted any specific provider by the service chief. A review of PI data over 18 months showed that the identified service accounted for less than 6 percent of patient care delays, and there was no individual provider identified with a higher percentage of delays than with the other providers.

## Conclusions

We did not substantiate any of the allegations. We found evidence of appropriate administrative practices by the service chief. Although the service chief did not have facility specific requirements for requesting physician re-privileging documented, the facility leadership recognized that all providers' credentialing and privileging requirements needed revision. Facility leadership is taking steps to clarify requirements for documentation of clinical competence for re-privileging for all facility providers.

OHI inspectors from the recent Combined Assessment Program review will follow up on facility physician privileging revisions. The service chief did have recent patient care involvement and did not cause patient care delays related to assigned providers.

We made no recommendations.

## Comments

The VISN and System Directors concurred with our findings. See Appendixes A and B, pages 4–5 for the full text of their comments.

*(original signed by:)*

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

**Appendix A**

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** June 2, 2011

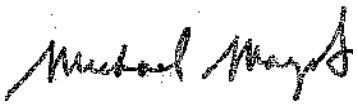
**From:** Director, VA New England Healthcare System (10N1)

**Subject:** **Healthcare Inspection – Provider Privileging and Delayed Patient Care, VA Connecticut Healthcare System, West Haven, Connecticut**

**To:** Director, Dallas Office of Healthcare Inspections (54DA)

**Thru:** Director, VHA Management Review Service (10A4A4)

VA New England Healthcare System (10N1) concurs with this report.



Michael Mayo-Smith, MD, MPH
Director, VA New England Healthcare System (10N1)

**Appendix B**

# Facility Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** June 2, 2011

**From:** Director, VA Connecticut Healthcare System (689/00)

**Subject:** **Healthcare Inspection – Provider Privileging and Delayed Patient Care, VA Connecticut Healthcare System, West Haven, Connecticut**

**To:** Director, VA New England Healthcare System (10N1)

VA Connecticut Healthcare System reviewed this healthcare inspection report and concurs with the findings.

(*original signed by*:)
Vincent Ng
Director, VA Connecticut Healthcare System (689/00)

**Appendix C**

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| OIG Contact | For more information about this report, please contact the Office of Inspector General at (202) 461-4720 |
| Acknowledgments | Cathleen King, RN, Project Leader<br>Maureen Washburn, RN, Team Leader<br>Larry Ross, MS<br>Robert Yang, MD, Medical Consultant<br>Misti Kincaid, BS, Program Support Assistant |

**Appendix D**

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